STATE OF FLORIDA
DEPARTMENT OF JUVENILE JUSTICE

BUREAU OF MONITORING AND QUALITY IMPROVEMENT
PROGRAM REPORT FOR

Daytona Juvenile Residential Facility
TrueCore Behavioral Solutions, LCC
(Contract Provider)
1386 Indian Lake Road
Daytona Beach, Florida 32124

Review Date(s): September 25-28, 2018

PROMOTING CONTINUOUS IMPROVEMENT AND ACCOUNTABILITY
IN JUVENILE JUSTICE PROGRAMS AND SERVICES

Rating Definitions

Ratings were assigned to each indicator by the review team using the following definitions:

Satisfactory Compliance	No exceptions to the requirements of the indicator; or limited, unintentional, and/or non-systemic exceptions that do not result in reduced or substandard service delivery; or systemic exceptions with corrective action already applied and demonstrated.
Limited Compliance	Systemic exceptions to the requirements of the indicator; exceptions to the requirements of the indicator that result in the interruption of service delivery; and/or typically require oversight by management to address the issues systemically.
Failed Compliance	The absence of a component(s) essential to the requirements of the indicator that typically requires immediate follow-up and response to remediate the issue and ensure service delivery.

Review Team

The Bureau of Monitoring and Quality Improvement wishes to thank the following review team members for their participation in this review, and for promoting continuous improvement and accountability in juvenile justice programs and services in Florida:

Jillian Lewandowski, Office of Program Accountability, Lead Reviewer (Standard 1)
Jenna Hester, DJJ Probation, Circuit 7, Senior Juvenile Probation Officer (Standard 5 and Interviews)
Mike Marino, Office of Program Accountability, Regional Monitor (Standard 4)
Gwen Nelson, Office of Program Accountability, Regional Monitor (Standard 3)
Irma Terry, Marion Regional Juvenile Detention Center, Superintendent (Standard 5)
Marla Vose, Marion Youth Academy, Sequel TSI, Director of Case Management (Standard 2)

Program Name: Daytona Juvenile Residential Facility | MQI Program Code: 1226
Provider Name: TrueCore Behavioral Solutions, LLC | Contract Number: R2107
Location: Volusia County / Circuit 7 | Number of Beds: 33
Review Date(s): September 25-28, 2018 | Lead Reviewer Code: 167

Methodology

This review was conducted in accordance with FDJJ-2000 (Contract Management and Program Monitoring and Quality Improvement Policy and Procedures), and focused on the areas of (1) Management Accountability, (2) Assessment and Performance Plan, (3) Mental Health and Substance Abuse Services, (4) Health Services, and (5) Safety and Security, which are included in the Residential Standards.

Persons Interviewed

- ☒ Program Director
- ☐ DJJ Monitor
- ☒ DHA or designee
- ☒ DMHCA or designee
- 1 # Case Managers
- 1 # Clinical Staff
- _____ # Food Service Personnel
- 1 # Healthcare Staff
- 1 # Maintenance Personnel
- 1 # Program Supervisors
- 7 # Staff
- 7 # Youth
- 2 # Other (listed by title): **Assistant Facility Administrator, Education Coordinator**

Documents Reviewed

- ☐ Accreditation Reports
- ☐ Affidavit of Good Moral Character
- ☒ CCC Reports
- ☐ Confinement Reports
- ☒ Continuity of Operation Plan
- ☒ Contract Monitoring Reports
- ☒ Contract Scope of Services
- ☒ Egress Plans
- ☒ Escape Notification/Logs
- ☒ Exposure Control Plan
- ☒ Fire Drill Log
- ☒ Fire Inspection Report
- ☒ Fire Prevention Plan
- ☒ Grievance Process/Records
- ☒ Key Control Log
- ☒ Logbooks
- ☒ Medical and Mental Health Alerts
- ☒ PAR Reports
- ☒ Precautionary Observation Logs
- ☒ Program Schedules
- ☒ Sick Call Logs
- ☒ Supplemental Contracts
- ☒ Table of Organization
- ☒ Telephone Logs
- ☒ Vehicle Inspection Reports
- ☒ Visitation Logs
- ☒ Youth Handbook
- 7 # Health Records
- 7 # MH/SA Records
- 10 # Personnel Records
- 13 # Training Records/CORE
- 4 # Youth Records (Closed)
- 7 # Youth Records (Open)
- 5 # Other: **Administrative Rule, Training Calendars, Facility Operating Procedures, Advisory Board Minutes, and Security Audits**

Surveys

- 7 # Youth
- 7 # Direct Care Staff
- _____ # Other: _____

Observations During Review

- ☐ Admissions
- ☐ Confinement
- ☒ Facility and Grounds
- ☒ First Aid Kit(s)
- ☒ Group
- ☒ Meals
- ☒ Medical Clinic
- ☒ Medication Administration
- ☒ Posting of Abuse Hotline
- ☒ Program Activities
- ☒ Recreation
- ☒ Searches
- ☒ Security Video Tapes
- ☒ Sick Call
- ☒ Social Skill Modeling by Staff
- ☒ Staff Interactions with Youth
- ☒ Staff Supervision of Youth
- ☒ Tool Inventory and Storage
- ☒ Toxic Item Inventory and Storage
- ☐ Transition/Exit Conferences
- ☐ Treatment Team Meetings
- ☐ Use of Mechanical Restraints
- ☒ Youth Movement and Counts

Comments

Items not marked were either not applicable or not available for review.

Standard 1: Management Accountability
Residential Rating Profile

Indicator Ratings

Standard 1 - Management Accountability		
1.01	* Initial Background Screening	Satisfactory
1.02	Five-Year Rescreening	Satisfactory
1.03	* Provision of an Abuse-Free Environment	Satisfactory
1.04	* Management Response to Allegations	Satisfactory
1.05	* Incident Reporting (CCC)	Satisfactory
1.06	Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory
1.07	* Pre-Service/Certification Requirements	Satisfactory
1.08	In-Service Training	Satisfactory
1.09	Grievance Process	Satisfactory
1.10	Delinquency Intervention and Facilitator Training	Satisfactory
1.11	Life Skills Training Provided to Youth	Satisfactory
1.12	Restorative Justice Awareness for Youth	Satisfactory
1.13	Gender-Specific Programming	Satisfactory
1.14	*Internal Alerts System and Alerts (JJIS)	Satisfactory
1.15	Youth Records (Healthcare and Management)	Satisfactory
1.16	Youth Input	Satisfactory
1.17	Advisory Board	Satisfactory
1.18	Program Planning	Satisfactory
1.19	Staff Performance	Satisfactory

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Standard 2: Assessment and Performance Plan
Residential Rating Profile

Indicator Ratings

Standard 2 - Assessment and Performance Plan		
2.01	Initial Contacts to Parent/Gaurdian and Court Notification	Satisfactory
2.02	Youth Orientation	Satisfactory
2.03	Written Consent of Youth Eighteen or Older	Satisfactory
2.04	Classification Factors, Procedures, and Reassessment for Activities	Satisfactory
2.05	Gang Identification: Notification of Law Enforcement	Satisfactory
2.06	Gang Identification: Prevention and Intervention Activities	Satisfactory
2.07	R-PACT Assessment and Reassessments	Satisfactory
2.08	Youth Needs Assessment Summary	Satisfactory
2.09	*Performance Plan Development, Goals and Transmittal	Satisfactory
2.10	Performance Plan Revisions	Satisfactory
2.11	Performance Plan Revisions	Satisfactory
2.12	Parent/Guardian Involvement in Case Management Services	Satisfactory
2.13	Members of Treatment Team	Satisfactory
2.14	Incorporation of Other Plans Into Performance Plan	Satisfactory
2.15	Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory
2.16	Career Education	Satisfactory
2.17	Educational Access	Satisfactory
2.18	Education Transitions Plan	Satisfactory
2.19	Transitions Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory
2.20	Exit Portfolio	Satisfactory
2.21	Exit Conference	Satisfactory

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Standard 3: Mental Health and Substance Abuse Services
Residential Rating Profile

Indicator Ratings

Standard 3 - Mental Health and Substance Abuse Services		
3.01	Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory
3.02	* Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.03	Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory
3.04	Mental Health and Substance Abuse Admission Screening	Satisfactory
3.05	Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory
3.06	Mental Health and Substance Abuse Treatment	Satisfactory
3.07	* Treatment and Discharge Planning	Satisfactory
3.08	* Specialized Treatment Services	Satisfactory
3.09	* Psychiatric Services	Satisfactory
3.10	* Suicide Prevention Plan	Satisfactory
3.11	* Suicide Prevention Services	Satisfactory
3.12	* Suicide Precaution Observation Logs	Satisfactory
3.13	* Suicide Prevention Training	Satisfactory
3.14	* Mental Health Crisis Intervention Services	Satisfactory
3.15	* Crisis Assessments	Satisfactory
3.16	* Emergency Mental Health and Substance Abuse Services	Satisfactory
3.17	* Baker and Marchman Acts	Non-Applicable

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Standard 4: Health Services
Residential Rating Profile

Indicator Ratings

Standard 4 - Health Services		
4.01	* Designated Health Authority/Designee	Satisfactory
4.02	Facility Operating Procedures	Satisfactory
4.03	Authority for Evaluation and Treatment	Satisfactory
4.04	Parental Notification	Satisfactory
4.05	Notification - Clinical Psychotropic Progress Note	Satisfactory
4.06	Immunizations	Satisfactory
4.07	Healthcare Admission Screening Form	Satisfactory
4.08	Medical Alerts	Satisfactory
4.09	Youth Orientation to Healthcare Services	Satisfactory
4.10	Designated Health Authority/Designee Admission Notification	Satisfactory
4.11	Healthcare Admission Rescreening	Satisfactory
4.12	Health Related History	Satisfactory
4.13	Comprehensive Physical Assessment	Satisfactory
4.14	Female-Specific Screening/Examination	Non-Applicable
4.15	Tuberculosis Screening	Satisfactory
4.16	Sexually Transmitted Infection Screening	Satisfactory
4.17	HIV Testing	Satisfactory
4.18	Sick Call Process - Requests/Complaints	Satisfactory
4.19	Sick Call Process - Visits/Encounters	Satisfactory
4.20	Restricted Housing	Non-Applicable
4.21	Episodic/First Aid Care	Satisfactory
4.22	Emergency Care	Satisfactory
4.23	Off-Site Care/Referrals	Satisfactory
4.24	Chronic Illness/Periodic Evaluations	Satisfactory
4.25	Medication Management - Verification	Satisfactory
4.26	Medication Management - Orders/Prescriptions	Satisfactory
4.27	Medication Management - Storage	Satisfactory
4.28	Medication Management - Medication and Sharps Inventory	Satisfactory
4.29	Medication Management - Controlled Medications	Satisfactory
4.30	Medication Management - Medication Administration Record	Satisfactory
4.31	Medication Management - Medication Administration By Licensed Staff	Satisfactory
4.32	Medication Management - Medication Provided By Non-Licensed Staff	Satisfactory
4.33	Medication Management - Psychotropic Medication Monitoring	Satisfactory
4.34	Infection Control - Surveillance, Screening, and Management	Satisfactory
4.35	Infection Control - Education	Satisfactory
4.36	Infection Control - Exposure Control Plan	Satisfactory
4.37	Prenatal Care - Physical Care of Pregnant Youth	Non-Applicable
4.38	Prenatal and Neonatal Care - Nutrition, Education of Youth, and Lactation	Non-Applicable
4.39	Prenatal and Neonatal Staff Education	Non-Applicable

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Standard 5: Safety and Security
Residential Rating Profile

Indicator Ratings

Standard 5 - Safety and Security		
5.01	Youth Supervision	Satisfactory
5.02	Comprehensive and Consistent Implementation of the Behavior Mgt System and Staff Training	Satisfactory
5.03	Behavior Management System Infractions and System Monitoring	Satisfactory
5.04	*Ten Minute Checks	Satisfactory
5.05	Census, Counts, and Tracking	Satisfactory
5.06	Logbook entries and Shift Report Review	Satisfactory
5.07	Key Control	Failed
5.08	Contraband Procedure	Satisfactory
5.09	Searches and Full Body Visual Searches	Satisfactory
5.10	Vehicals and Maintenance	Satisfactory
5.11	Transportation of Youth	Satisfactory
5.12	Weekly Safety and Security Audit	Satisfactory
5.13	Tool Inventory and Mangement	Satisfactory
5.14	Youth Tool Handling and Supervision	Limited
5.15	Outside Contractors	Satisfactory
5.16	Fire, Safety, and Evacuation Drills	Satisfactory
5.17	Disaster and Continuity of Operations Planning (COOP)	Satisfactory
5.18	Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.19	Youth Handlins and Supervison of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory
5.20	Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory
5.21	Recreation and Leisure Activities	Satisfactory
5.22	*Elements of the Water Safety Plan, Staff Training, and Swim Test	Non-Applicable
5.23	Visitation and Communication	Satisfactory
5.24	Search and Inspection of Controlled Observation Room	Non-Applicable
5.25	Controlled Observation	Non-Applicable
5.26	Controlled Observation Safety Checks and Release Procedures	Non-Applicable

* The Department has identified certain key critical indicators. These indicators represent critical areas that require immediate attention if a program operates below Department standards. A program must therefore achieve at least a Satisfactory Compliance rating in each of these indicators. Failure to do so will result in a program alert form being completed and distributed to the appropriate program area (detention, residential, probation).

Strengths and Innovative Approaches

- During family day at Daytona Juvenile Residential Facility, the program offers the youth and families an opportunity to participate in a photo booth. The program wants to capture the family memories during each youth's length of stay. During family day the photo book has a theme, for example, football Friday or 70's Day, etc. The program wants to preserve the moment in time and for the family to reflect on the memory of the day.

Standard 1: Management Accountability

Overview

The Daytona Juvenile Residential Facility is a thirty-three bed, secure sex offender treatment program located in Daytona Beach, Florida. The program is operated by TrueCore Behavioral Solutions, LLC, through a contract with the Department. The management team consists of a facility administrator, assistant facility administrator, clinical director, community case manager, health services administrator, and four shift supervisors. Management meetings are conducted each weekday morning to discuss any scheduling issues, staff issues, youth issues, and any other operational concerns. The program also conducts case management, community advisory board, youth advisory board, shift manager, and all-staff meetings. The program surveys parents/guardians and youth monthly regarding services for the youth. The program has experienced considerable staff turnover. According to the staff roster, seven full-time staff and one part-time staff were hired since the last annual compliance review. At the time of the annual compliance review, staff vacancies included thirteen youth care workers, one case manager, and one physical plant manager. In attempt to fill the position vacancies, the facility administrator (FA) has asked corporate for additional pay. The FA also stated he was working with the local colleges/universities to try to recruit potential staff and has also held job fairs.

1.01 Initial Background Screening (Critical)	Satisfactory Compliance
Background screening is conducted for all Department employees, contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth. The background screening process is completed prior to hiring an employee or utilizing the services of a volunteer, mentor, or intern. An Annual Affidavit of Compliance with Level 2 Screening Standards is completed annually.	

Background screening is to be completed for staff, volunteers, contractors, and interns prior to their date of hire or services being provided. Since the last annual compliance review the program had three volunteers start and the program hired eight staff to include four youth care workers, one transition service manager, one recreational therapist, one health services administrator, and one part-time therapist. A review of the Department's Background Screening Unit/Clearinghouse screenings and personnel records reflected each staff member and volunteer were background screened prior to their date of hire or date of volunteering. Staff are added to the program's Clearinghouse employment roster. An Annual Affidavit of Compliance with Level 2 Screening Standards was submitted by the program to the Department's Background Screening Unit (BSU) on January 24, 2018, meeting the annual requirement. Education staff at the program are funded through the Volusia County School Board who also submitted an Annual Affidavit of Compliance with Level 2 Screening Standards to the BSU on January 24, 2018. A pre-employment assessment tool began in February 2018 for direct care applicants. Documentation reflected an oath was signed by the test administrator on February 9, 2018. Two of the eight staff hired were applicable for requiring a pre-employment assessment tool based on their date of hire. Each applicable staff member completed the assessment tool with a passing score and documentation of the passing score was maintained in the staff's personnel record.

1.02 Five-Year Rescreening	Satisfactory Compliance
Background rescreening/resubmission is conducted for all Department employees and volunteers and all, contracted provider and grant recipient employees, volunteers, mentors, and interns with access to youth and confidential youth records. Employees and volunteers are rescreened every five years from the initial date of employment. When a current provider staff member transitions into the Clearinghouse, the rescreen/resubmission date starts anew and is calculated by the Clearinghouse. (Note: For the new date, see the Retained Prints Expiration Date on the applicant's personal profile page within the Clearinghouse.).	

Three staff members were applicable requiring a five-year rescreening based on their date of hire and anniversary dates. Each staff member had a five-year rescreening completed. One of the three rescreens was submitted to the Department's Background Screening Unit/Clearinghouse at least ten business days prior to the five-year anniversary date. The remaining two five-year re-screenings were submitted beyond the ten business days prior to the anniversary date with one being submitted eight days late and one being seven days late. The program acknowledged the late rescreens were detected and corrected internally as the most recent rescreen was submitted timely. The volunteer roster did not reflect any volunteers requiring a five-year rescreening.

1.03 Provision of an Abuse-Free Environment (Critical)	Satisfactory Compliance
The program provides an environment in which youth, staff, and others feel safe, secure, and not threatened by any form of abuse or harassment. • *Posting of the Florida Abuse Hotline telephone number and the Central Communications Center for youth 18 years of age and older telephone number.* • *All allegations of child abuse or suspected child abuse are immediately reported to the Florida Abuse Hotline.* • *Youth and staff have unhindered access to report alleged abuse to the Florida Abuse Hotline pursuant to Section 39.201 (1)(a), F.S.* • *The environment is free of physical, psychological, and emotional abuse.* • *A code of conduct for staff who clearly communicates expectations for ethical and professional behavior, including the expectation for staff to interact with youth in a manner promoting their emotional and physical safety.*	

The program has a policy and procedures addressing abuse and neglect reporting to include the steps to report the alleged abuse or neglect. According to the program's policy, staff are to immediately report alleged or suspected abuse to the Florida Abuse Hotline or the Department's Central Communications Center (CCC) if the youth is eighteen years of age or older. If the youth refuses to contact the Florida Abuse Hotline, staff are to contact the hotline. Staff are to notify the on-duty supervisor when calls are placed. An internal incident report is to be completed and forwarded to the supervisor once the call is placed to the Florida Abuse Hotline or CCC.

The program has the Florida Abuse Hotline telephone number and the CCC telephone number posted throughout the facility. Staff are required to sign a code of conduct, which is included as part of the employee handbook. A random sample of three staff personnel records were reviewed and each record contained the staff member's documented signature on the employee handbook to confirm this practice. Since the last annual compliance review, the program had five incidents of abuse allegations. Four incidents involved allegations against staff, with one incident alleging improper supervision after a complaint by a parent/guardian of youth on youth incidents. All five incidents were reported to the CCC. Two of the incidents involved youth who were eighteen years of the age. The remaining three incidents involved youth under the age of eighteen and each incident was reported to the Florida Abuse Hotline. The three incidents reported to the Florida Abuse Hotline cited the Department of Children and Families (DCF) closed their investigations with no indicators. Corrective action, to include an oral warning and retraining, was taken for the staff member with substantiated findings of improper use of force. One staff member was the staff cited for a substantiated finding of improper conduct of a staff with youth relationship. The staff resigned immediately and is ineligible for rehire.

Seven interviewed youth reported they feel safe at the program. Each youth reported they have not been stopped from reporting abuse to the Florida Abuse Hotline or the CCC. When asked if staff are respectful when speaking with the youth, five youth indicated some staff are respectful and staff will use profanity. When asked specifically if they have heard curse words by staff, four youth stated staff occasionally use profanity, one youth stated often, and one youth stated they heard profanity once. One youth indicated they have never heard a staff member use profanity. Seven staff were interviewed, and each staff member reported they have not observed a co-worker tell a youth they could not contact the Florida Abuse Hotline or the CCC. Five staff members indicated the youth and staff are able to contact the Florida Abuse Hotline with one staff member indicating the supervisor makes the abuse call, and one indicating the assistant facility administrator or facility administration makes the abuse call. Four staff reported the supervisor and facility administrator are notified of the incident as soon as possible once the call is completed. Six staff members reported they have not observed a co-worker use profanity when speaking with youth, using threats, intimation, or humiliation when interacting with youth. One staff member reported they have observed a co-worker use profanity in general, but not towards the youth. An interview with the facility administrator indicated the assistant facility administrator or facility administrator are notified of the incident whether it be an abuse allegation or incident which needs to be called into the CCC. The facility administrator stated the regional director is notified of the incident. According to the facility administrator, the contact information for the Florida Abuse Hotline and the CCC are discussed during the youth community meeting and all campus meetings. The calls are also discussed during the morning management meetings. All calls made to the Florida Abuse Hotline and CCC are documented in the logbook.

1.04 Management Response to Allegations (Critical)	**Satisfactory Compliance**
Management shall be cognizant of youth and staff needs and provide direction to each on how to access the Florida Abuse Hotline. There is evidence management takes immediate action to address incidents of physical, psychological, and emotional abuse.	

Since the last annual compliance review, four allegations were made against staff for incidents of physical, psychological, or emotional abuse. Documentation included in the staff's personnel records reflected management took immediate action to address the allegations. One staff member resigned immediately, two were placed on no youth contact, and the remaining staff

was given an oral reprimand and training. One staff on no youth contact was terminated and the other staff received additional training. A Notice of Return from No Youth Contact was documented in the staff's personnel file after the additional training was completed. An interview with the facility administrator confirmed the information for contacting the Florida Abuse Hotline and the Department's Central Communications Center (CCC) are posted throughout the program and are discussed during the youth community meeting and all campus staff meeting. According to the facility administrator, the contact information for the Florida Abuse Hotline and the CCC are discussed during the youth community meeting and all campus meetings for the youth and staff to be aware. During an interview with the facility administrator, it was reported following any investigation, if allegations are found to be true, the employee will be suspended or terminated.

1.05 Incident Reporting (CCC) (Critical)	Satisfactory Compliance
Whenever a reportable incident occurs, the program notifies the Department's Central Communications Center (CCC) within two hours of the incident, or within two hours of becoming aware of the incident.	

In the last six months, the program had a total of eleven incidents reported to the Department's Central Communications Center (CCC). A total of five incidents reported to the CCC were reviewed. Each incident was reported to the CCC within two hours of the incident or within two hours of the individual becoming aware of the incident. Four incidents involved a complaint against staff, and one was for a medical incident. Each report to the CCC was documented in the facility logbook. A review of the youth grievances did not reflect any additional incidents which should have been reported to the CCC. An interview with the facility administrator indicated the assistant facility administrator or facility administrator are notified of incidents who then notified the regional director of the incident.

1.06 Protective Action Response (PAR) and Physical Intervention Rate	Satisfactory Compliance
The program uses physical intervention techniques in accordance with Florida Administrative Code. Any time staff uses a physical intervention technique, such as countermoves, control techniques, takedowns, or application of mechanical restraints (other than for regular transports), a PAR Incident Report is completed and filed in accordance with the Florida Administrative Code.	

In the last six months, the program had six incidents involving the use of Protective Action Response (PAR). Five of the six incidents involving PAR were reviewed. Each incident report documented the PAR report was completed by the end of the staff member's workday. Four of the five reports including statements from all staff involved. One PAR incident report did not include a statement from the witness to the incident. None of the incidents documented the use of mechanical restraints. Each report documented a review by a PAR certified instructor or supervisory staff. Two of the incidents indicated the use of PAR resulted in an injury to the youth or staff and the Department's Central Communications Center (CCC) was contacted in both instances. One youth alleged abuse and the Florida Abuse Hotline was contacted. A PAR medical review was completed for the two applicable youth. A post-PAR interview was conducted with the youth in all five incidents as soon as possible or within thirty minutes of the incident. Four of the five PAR incident reports were reviewed by the superintendent or designee within seventy-two hours. The remaining PAR incident did not include a review by the facility administrator or designee. All of the PAR incidents were documented in a centralized binder

organized by month. The program has an approved PAR plan which was signed by the Department and the Office of Staff Development and Training.

An interview with the facility administrator indicated all PAR incidents are discussed during the morning management meeting, and a video review of the incident is conducted by the assistant facility administrator. The facility administrator also stated staff are trained on ways to avoid using physical interventions during the all campus staff meetings.

The program's PAR rate during the annual compliance review period was 1.06, which is below the statewide Residential PAR rate of 1.29.

1.07 Pre-Service/Certification Requirements (Critical)	Satisfactory Compliance
Contracted and State residential staff satisfies pre-service/certification requirements specified by Florida Administrative Code within 180 days of hiring.	

Since the last annual compliance review, the program has hired eight staff. Eight staff training records were reviewed for pre-service, and certification requirements. Seven staff completed the essential pre-service training which must be completed prior to any contact with youth to include cardiopulmonary resuscitation, first aid, automated external defibrillator (AED), ethics, Prison Rape Elimination Act (PREA), human trafficking, emergency procedures, child abuse reporting, restorative justice, and ten hours of suicide prevention training to include two hours in the Department's Learning Management System (SkillPro). In addition, each staff completed trauma informed care, and restorative justice training. Seven of the eight staff members completed forty-hours of Protective Action and Response (PAR). The remaining staff member was being terminated by the provider after failing to pass the PAR exam. Four of the eight staff have been hired with the program for at least 180 days; therefore, requiring the minimum of 120 hours of pre-service training to be completed for certification. All four applicable staff completed the required training hours with a total number of hours ranging from 121.5 to 172 hours. The four remaining staff members have not been employed by the program more than 180 days. Staff also complete a forty-hour on-the-job training plan. The program submitted a list of pre-service training to the Office of Staff Development and Training to include course names, descriptions, objectives, and training hours on December 18, 2017. All training was documented in the Department's Learning Management System (Skill Pro).

1.08 In-Service Training	Satisfactory Compliance
Residential staff complete twenty-four hours of in-service training, including mandatory topics specified in Florida Administrative Code, each calendar year, effective the year after pre-service/certification training is completed. *Supervisory staff completes eight hours of training (as part of the twenty-four hours of annual in-service training) in the areas specified in Florida Administrative Code.*	

Six staff members were applicable for review of in-service training based on their dates of hire. Each staff member completed in-service training to include cardiopulmonary resuscitation, first aid, automated external defibrillator (AED), ethics, suicide prevention, and an eight-hour Protective Action Response (PAR) update. Each staff completed Prison Rape Elimination Act (PREA), trauma informed care, human trafficking for direct care staff, and stress management. Three of the staff records reviewed were for supervisors. Each supervisor completed more than the required eight hours of supervisory training with hours ranging from thirteen to eighteen hours. Each supervisor completed courses in management, leadership, employee relations,

communication skills, and fiscal training. Each supervisor completed training on outcome based corrective action plans (OBCAPs), critical thinking, organizational skills, delivering constructive criticism, and a course titled What Providers Need to Know When Doing Business with the State of Florida. All training was documented in the Department's Learning Management System (Skill Pro). The program maintains an annual in-service training calendar and the list of in-service trainings were submitted to the Office of Staff Development and Training to include course names, descriptions, objectives, and training hours. The 2018 training plan was submitted on December 28, 2017.

1.09 Grievance Process	Satisfactory Compliance
Program staff shall be trained on the program's youth grievance process and procedures. The program adheres to their grievance process and shall ensure it is explained to youth during orientation and grievance forms are available throughout the facility. *Completed grievances shall be maintained by the program for a minimum of twelve months.*	

The program has a policy and procedures addressing the grievance process. The grievance procedures detail the three grievance phases to include the informal phase, formal phase, and appeal phase. The policy indicated the informal phase is an attempt to resolve questions and disputes through informal communication with staff and is to be completed within forty-eight hours of the grievance. The formal phase involves a grievance officer who investigations and is to render a decision. The appeal phase is a review by the facility administrator or assistant facility administrator. According to policy, the formal review process is to be completed within seventy-two hours, including reporting back to the youth. Five youth grievances completed within the last six months were reviewed. Each grievance documented the nature of the grievance, whether or not the informal phase was completed, the completion of the formal phase, and the date the grievance was resolved with the youth. Four of the five grievances documented the facility administrator or assistant facility administrator addressed and resolved the grievance with the youth within seventy-two hours. One grievance documented the facility administrator addressed the grievance ninety-six hours after the grievance was received. The program has maintained copies of the grievances for the past twenty months.

Seven youth were interviewed regarding the grievance process. Each youth was able to identify once a grievance is fill out, they are placed in one of the two grievance boxes located in the program. Each youth indicated they can ask for assistance in completing a grievance form.

An interview with the facility administrator indicated youth complete a grievance form and place in the grievance box on the unit or in dayroom two. The assistant facility administrator or vocational instructor retrieve the grievances and discuss the matter with the youth to try to resolve the grievance. If the youth does not agree with the decision made by the vocational instructor, the grievance is forwarded to the facility administrator. When an agreeable decision is made, the youth signs and dates the grievance, which is then recorded in the grievance log with a designated grievance number.

1.10 Delinquency Interventions and Facilitator Training	Satisfactory Compliance
The program shall implement a delinquency intervention model or strategy that is an evidence-based practice, promising practice, or a practice with demonstrated effectiveness, for each youth. Staff whose regularly assigned job duties include implementation of a specific delinquency intervention model, strategy, or curriculum receive training in its effective implementation.	

The delinquency interventions being utilized at the program include Pathways, Thinking for a Change (T4C), and Impact of Crime (IOC). Thinking for a Change (T4C) and Pathways are identified as an evidence-based intervention. Impact of Crime is identified as a promising practice. The program is not currently conducting IOC, which the clinical director indicated was due to a lack of enough new youth to start a new cycle. Nine staff were identified as facilitators delivering delinquency interventions. Each staff member has the required education and work experience to deliver the intervention services they are providing. Training records confirmed each staff member was trained to provide the interventions they are facilitating. The program's activity schedule reflects the program is providing structured, planned programming and activities to include the delinquency interventions at least sixty percent of the youth's awake hours. Performance plans addressed an identified need and youth are involved in a delinquency intervention to address the identified need. Group sign-in sheets confirmed the youth's participation in the delinquency interventions. An interview with the facility administrator confirmed the program utilizes Pathways, IOC, and T4C as their delinquency interventions. The facility administrator reported youth are matched to counselors and case manager for interventions based on the staff most suitable to meet the needs of the youth according to their electronic commitment packet (ECP).

1.11 Life Skills Training Provided to Youth	Satisfactory Compliance
The program shall provide interventions or instruction focusing on developing life and social skill competencies in youth.	

Life skills training is provided at the program utilizing the curriculum Life Skills 225. Each week for one hour, youth attend a social skills and coping skills group, which incorporates the life skills training. The youth also attend a separate group for an hour each week for anger management and conflict resolution. The program's activity schedule reflects these groups are conducting on Monday and Friday each week. Group sign-in sheets confirm topics address life skills such as social skills, how to conduct yourself during a job interview, how to apply for a job, getting and keeping a job, prioritizing activities, putting things in order, communication, anger management, and conflict resolution. The youth records indicate they are receiving services as outlined. Staff training records confirm they have been trained to deliver the curriculum. Seven youth interviews were conducted, and each youth was able to identify groups they are currently participating in and new skills or behaviors they have been taught in these groups to include coping skills, recognizing thinking errors, anger management, and positive self-talk. Each youth indicates the skills learned are practiced during group and outside of group.

1.12 Restorative Justice Awareness for Youth	Satisfactory Compliance
The program shall provide activities or instruction intended to increase youth awareness of, and empathy for, crime victims and survivors, and increase personal accountability for youths' criminal actions and harm to others.	

The program conducts Impact of Crime (IOC) and Pathways groups as restorative justice awareness for youth to increase accountability for criminal actions and harm to others. The program is not currently conducting IOC, which the clinical director indicated was due to a lack of enough new youth to start a new cycle. Pathways is an open group and is currently occurring each week on Tuesday and Thursday. Services are being delivered as outlined and were confirmed by reviewing the sign-in sheets, as well as an observation being conducted of the Pathway group by members of the Department's Programming and Technical Assistance Unit. Four staff members facilitate Pathways to include three therapists and the clinical director. Two staff members facilitate IOC to include the vocational instructor and a youth care worker II. Training records confirmed the six staff are trained to deliver these services. An interview with the facility administrator confirmed the program provides Pathways and IOC as restorative justice awareness programming. The youth are not permitted to participate in off-campus activities; however, community service hours are completed on-site. The program has a victim wall in the case management area and the program utilizes a victim chair to represent the youth's victim as a reminder of the impact of their crime.

1.13 Gender-Specific Programming	Satisfactory Compliance
The program provides delinquency intervention and gender-specific treatment services.	

The program utilizes the Young Men's Work: Stopping Violence and Building Community curriculum as gender-specific programming. Young Men's Work is a program for young men, ages fourteen to nineteen, who are working together to solve problems without resorting to violence. The curriculum contains twenty-six sections which includes objectives, an agenda, session, and exercises. The gender-specific programming is conducted on Monday in rotation with anger management. An interview the facility administrator confirmed Young Men's Work is the curriculum utilized at the program for gender-specific programming. The programming was included on the activity schedule, which is conducted on Monday in rotation with anger management. The material discusses ways to solve problems without resorting to violence, which addresses needs identified for the youth.

1.14 Internal Alerts System and Alerts (JJIS) (Critical)	Satisfactory Compliance
The program shall maintain and use an internal alert system easily accessible to program staff and keeps them alerted about youth who are security or safety risks, and youth with health-related concerns, including food allergies and special diets. When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into its internal alert system. The program ensures only appropriate staff may recommend downgrading or discontinuing a youth's alert status. *When risk factors or special needs are identified during or subsequent to the classification process, the program immediately enters this information into the Juvenile Justice Information System (JJIS). Upon recommendation from appropriate staff, JJIS alerts are downgraded or discontinued.*	

The program maintains an internal alert system which is easily accessible to program staff to ensure they are aware of any security concerns, safety risks, health-related concerns, allergies or special diets. The internal alert list and an alert board with each youth's picture and applicable alert level is located the staff briefing room, as well as a copy of the internal alert list is located in the medical clinic. The program has a policy and procedures addressing the medical, mental health, and security alert system. The policy addresses how alerts are identified, documented, updated, and communicated with employees. The program's internal alert list was compared to the Department's Juvenile Justice Information System (JJIS) alerts. One applicable medical alert was listed on the program's internal alert list; however, was not reflected in JJIS. One medical alert was listed in JJIS; however, was not reflected on the program's internal alert list. Both alerts were corrected and updated by the medical staff during the annual compliance review week. One suicide risk alert indicated a youth was stepped down from constant to close supervision; however, the suicide risk alert was still open in JJIS. The alert was corrected and updated by the mental health clinical staff during the annual compliance review week. The facility logbook was reviewed which documented changes in youth alert status. An interview with the facility administrator indicated the alert board in the personnel office has a picture of the youth and what level of alert is applicable for each youth. The various levels of alerts are represented by various colors, which include sports restrictions, medical issues, gang affiliation, mental health-suicide precautions, escape risk, security risk, violent behavior, or special alert. Observations on-site confirmed this practice. The facility administrator confirmed the medical department enters and closes the food allergies and medical alerts, the clinical department enters and closes the mental health alerts, and case management enters safety/security alerts. A review of JJIS confirmed this practice.

1.15 Youth Records (Healthcare and Management)	Satisfactory Compliance
The program maintains an official case record, labeled "Confidential," for each youth, which consists of two separate files: • *An individual healthcare record* • *An individual management record.*	

The program maintains separate youth records to include an individual healthcare record, and an individual management record. Seven youth management records were reviewed. Each management record contained a tab with the required information to include the youth's name, Department identification number, date of birth, county of residence, and the youth's committing offense. Each individual management record contained the required sections to include legal information, demographic and chronological information, correspondence, case management

and treatment team activities, and miscellaneous. Each record was labeled confidential and records are secured in a locked file cabinet or locked room, which was confirmed by observations during the annual compliance review week.

1.16 Youth Input	Satisfactory Compliance
The program has a formal process to promote constructive input by youth.	

The program has a formal process to promote constructive input by youth to include monthly youth surveys, a youth advisory board, and a youth community meeting. The youth community meetings are held at least twice each month, and the youth advisory board meetings are held on a monthly basis. The youth community meetings include an agenda to include a review of previous minutes, program issues, youth concerns, and youth ideas. Seven months of meeting minutes were reviewed for the youth advisory board. A sign-in sheet was completed for each meeting, as well as an agenda and minutes. Documentation of sign-in sheets and agendas for youth community meetings were also reviewed. Documentation reflected the youth community meetings were held at least twice each month with some months having meetings three and four times. A community meeting took place during the annual compliance review week. Seven youth were interviewed to determine if the program has a process to allow youth to provide input about what happens at the program. Five youth indicated the program has a process to allow for input with youth being able to identify the program conducts community meetings, monthly surveys, and has speak out forms. Two youth indicated the program does not have a process with one youth indicating the program does not consider the youth's input. An interview with the facility administrator indicated the youth are able to provide input during the youth advisory meeting, community meeting, and provide feedback by submitting a speak out form. Speak out forms are available for youth in the dorm and the dining room, which was confirmed by observations during the program tour. The facility administrator also indicated monthly youth surveys are completed as a way for the youth to provide feedback.

1.17 Advisory Board	Satisfactory Compliance
The program has a community support group or advisory board meeting at least quarterly. The program director solicits active involvement of interested community partners.	

The program has an established community advisory board which consists of the facility administrator or designee, law enforcement representative, judiciary staff, community partners, individuals from the business community, school board, faith community, victim advocate coordinator, and parents/guardians of youth who have graduated from the program. Documentation of sign-in sheets, agenda, and minutes were reviewed which reflected the community advisory board was conducted quarterly with meetings in January, June, and September 2018. It is noted the meetings were scheduled for ninety-day increments; however, the December meeting was cancelled and held in January 2018. The next meeting scheduled for March 2018 was also cancelled and the next meeting held was in June 2018. Another advisory board meeting has been scheduled for December 2018. A binder which included the advisory board information included letters from the facility administrator soliciting active involvement of interested community partners, including representatives from law enforcement, the judiciary, the school board or district, the business community, and the faith community. An interview with the facility administrator indicated the advisory board meetings are conducted in collaboration with the Volusia Regional Juvenile Detention Center and the meetings are rotated quarterly. The meetings are scheduled for 11:00 a.m. and last for approximately an hour and a half. The facility administrator confirmed the advisory board is comprised of representatives

from the Volusia County Sheriff's Office, Volusia County School Board, Volusia County Health Department, Bethune Cookman University, and Department staff. An advisory board member was not available to interview.

1.18 Program Planning	Satisfactory Compliance
The program uses data to inform their planning process and to ensure provisions for staffing.	

The program has a policy and procedures addressing a system of staff communication, opportunities to provide input, and feedback. An interview with the facility administrator indicated surveys are completed monthly with the youth, parent/guardians, and staff. The information from the surveys are discussed during the morning management meeting to devise a plan to improve in the areas identified in need of improvement. The program currently has fifteen vacancies to include one case manager, one physical plant manager, and thirteen youth care workers. An interview with the facility administrator indicated the program is working to find staff to fill the vacant positions. In an effort to minimize staff turner, the facility administrator indicated individual meetings are being held with staff for input, feedback, and to improve communication. There is a plan to implement a store for all staff to provide food and snacks. It was also announced at the annual compliance review, a monetary incentive to include a pay raise for staff was being put in place to try to retain staff. Staff meetings to include all staff are held on a monthly basis on the second Wednesday of the month. Documentation of minutes, agendas, and sign-in sheets confirmed twelve all campus staff meetings were held monthly. In addition, shift supervisor meetings are held on a monthly basis and daily morning management meetings. An interview with the facility administrator indicated the Comprehensive Accountability Report (CAR) is posted in the personnel office, which is also the staff break area. Observations during the annual compliance review week confirmed a copy is maintained in the staff break area. Seven staff were interviewed, and four staff reported they are briefed on CAR reports, annual compliance reports, and/or youth and parent/guardian survey results. When asked how effective staff believe communication is amongst the staff at this program, two staff reported very poor, one staff reported poor, two staff reported fair, and two staff reported good. The program has been short staffed for quite some time and the staff had a recent change of assist facility administrator (one month prior to the annual compliance review) and facility administrator (one week prior to the annual compliance review). The staff reported they feel communication can improve and hope with the new administration this can be accomplished.

1.19 Staff Performance	Satisfactory Compliance
The program ensures a system for evaluating staff, at least annually, based on established performance standards.	

The program has a policy and procedures addressing a system for evaluating staff, performance standards, and frequency of evaluations. Evaluations for staff are completed at least annually. An interview with the facility administrator indicated the supervisor is to complete an evaluation for their employees. Once the evaluations are completed, the evaluation is reviewed by the facility administrator. Once signed by the facility administrator, the evaluation is returned to the supervisor who will meet with the staff to discuss and review the evaluation. The staff member is to sign the evaluation and the original is maintained in the staff personnel record with a copy being provided to the employee. A sample of nine staff performance evaluations were reviewed for youth care workers, case management, and therapists. Evaluations are conducted at least on an annual basis based on established performance standards. Performance standards matched the job descriptions for each staff and included job specific

requirements of the position. For applicable staff, the performance evaluation included the staff's implementation of the program's behavior management system. The delivery of delinquency intervention services is identified as a job function for applicable staff on the performance evaluation. The intervention was listed on the applicable evaluations with the exception of two performance evaluations which did not list the specific intervention being provided, but each staff was evaluated on their level of skills when delivering a primary curriculum as supported by fidelity checks.

Standard 2: Assessment and Performance Plan

Overview

The program currently has one community case manager and one case manager. The program has one vacancy for a case manager. Case management staff are responsible for the orientation process, the classification process, and notifying all required parties of a youth's arrival to the program, progress while at the program, and transition from the program. Case managers are responsible for completing the Residential Positive Achievement Change Tool (R-PACT) assessment and reassessments, developing and completing the performance plans, completing and disseminating the performance summaries, and facilitating communication between the program and youth, parents/guardians, courts, Department of Children and Families (DCF), juvenile probation officers (JPO), Agency for Persons with Disabilities (APD), if applicable, stakeholders, and community partners. Case managers organize and coordinate informal and formal treatment teams, transition planning and transition meeting, exit conferences, and participate in the community reentry team meetings. Case managers also ensure completion of the educational exit plan and the exit portfolio.

2.01 Initial Contacts to Parent/Guardian and Court Notification	Satisfactory Compliance
The program notifies the youth's parent/guardian by telephone within twenty-four hours of the youth's admission, by written notification within forty-eight hours of admission, and notify the youth's committing court, assigned juvenile probation officer (JPO) and post residential services counselor (if applicable) in writing within five working days of any admission.	

The program has a policy and procedures to notify a youth's parent/guardian by telephone and by written notification on each youth's date of admission. Seven youth case management records were reviewed. Seven records documented the parents/guardians were called within twenty-four hours of the youth's arrival at the program. All seven records documented the written notification was sent to the parents/guardians on the date of admission and all court notification took place within five working days.

2.02 Youth Orientation	Satisfactory Compliance
The program shall provide each youth an orientation to the program rules, expectations, goals of the program, and services applicable to youth, to begin within the day of, or prior to, the youth's admission.	

The program has a policy and procedures to provide each youth an orientation to the program within twenty-four hours of their admission. The program utilizes an orientation checklist to explain and discuss program rules, schedules, and services available. Seven youth case management records were reviewed, and each record contained an orientation checklist completed on the youth's admission date. The checklist included the daily schedule, expectations of the youth, the behavioral management system, access to medical and mental health services, access to the Florida Abuse Hotline or Central Communications Center (CCC) if the youth is eighteen years or older, items considered contraband, and performance planning. The checklist also included the dress code, hygiene practices, procedures on visitation, mail, and use of the telephone, anticipated length of stay, community access, the grievance procedure, emergency procedures, the physical design of the facility, and the youth's assignment to the living unit, room, and treatment team. There were no intakes scheduled for

the week of the annual compliance review; therefore, orientation could not be observed. Seven youth were interviewed, and each youth indicated an orientation to the program including the program rules, procedures, and schedules occurred within twenty-four hours of their admission.

2.03 Written Consent of Youth Eighteen Years or Older	Satisfactory Compliance
The program obtains written consent of any youth eighteen years of age or older, unless the youth is incapacitated and has a court-appointed guardian, before providing or discussing with the parent/guardian any information related to the youth's physical or mental health screening, assessment, or treatment.	

The program has a policy and procedures for all youth eighteen years of age or older to sign consent forms on the day of admission or on the day of their eighteenth birthday. One record was applicable for youth eighteen years or older; therefore, two additional records were requested and reviewed. All three records contained a signed consent for the program to provide or discuss with the parent/guardian any information relating to the youth's physical or mental health screening, assessment, or treatment.

2.04 Classification Factors, Procedures, and Reassessment for Activities	Satisfactory Compliance
The program utilizes a classification system, in accordance with Florida Administrative Code, promoting safety and security, as well as effective delivery of treatment services. Initial classification should be used for the purposes of assigning each newly admitted youth to a living unit, sleeping room, and youth group or staff advisor. *Youth are reassessed and reclassified, if warranted, prior to considering an increase in privileges or freedom of movement, participation in work projects, or other activities involving tools or instruments that may be used as potential weapons or means of escape, or participation in any off-campus activity.*	

The program has a policy and procedures to assign a youth to a living and/or sleeping room on the day of admission. The program reviews classification factors such as physical characteristics, age and maturity, identified special needs, history of violence, gang affiliation, criminal behavior, sexual aggression or vulnerability to victimization, and any identified or suspected risk. Documentation reflected the Department's Juvenile Justice Information System (JJIS) alert list was reviewed for any issues affecting classification. Seven youth case management records were reviewed, and each contained a classification form completed on the youth's admission date regarding the youth's living and sleeping unit. The program maintains a continually updated, internal alert system which is easily accessible for program staff. The program maintains an internal alert board in the personnel office with each youth's picture and a color-coded level of alert to notify of any sports restrictions, medical issues, gang affiliation, mental health-suicide precautions, escape risk, security risk, violent behavior, or special alert. Seven youth case management records were reviewed, and each contained a reassessment of the youth's needs, risk factors and reclassification prior to an increase in the youth's privileges or freedom of movement, and participation in work projects or other activities involving tools. The youth do not participate in any off-campus activities. Documentation in the program's policy and procedures, individualized performance plans, treatment team notes, and performance summaries validate the practice for reclassification of youth prior to youth engaging in certain activities, including an increase in activities, freedom of movement, and participation in work projects. The program does not participate in off-campus activities.

An interview with the facility administrator indicated factors are considered when assigning the youth to a sleeping room. The program only has one living unit with individual rooms and all youth are assigned to their own room. The facility administrator indicated the treatment team attempts to put youth closer to the staff desk if they have a history of mental health issues or place room in a room further away from the exit doors if they have a history of escape. The program also places youth in a room surrounded by other youth who are closer in age.

2.05 Gang Identification: Notification of Law Enforcement	Satisfactory Compliance
The program shall gather information on gangs, (e.g., gang members, tattoos, other body markings) and share this information with law enforcement.	

The program has a policy and procedures in place regarding gang notification of law enforcement. Two youth currently in the program were applicable and identified as suspected gang affiliation or documented gang involvement. Local law enforcement and law enforcement in the youth's home county was notified of the youth's gang affiliation even when the youth were previously identified as gang members or affiliates prior to admission. Documentation reflected the youth's educational provider, juvenile probation officer (JPO) and/or post-residential counselor were notified of information relating the youth's gang status.

2.06 Gang Identification: Prevention and Intervention Activities	Satisfactory Compliance
A residential commitment program shall implement gang prevention and intervention strategies. The residential commitment program shall provide intervention strategies when youth are identified as being a criminal street gang member, are affiliated with any criminal street gang, or are affiliated with any criminal street gang, or are at high risk of gang involvement.	

The only two records applicable for gang affiliation were reviewed for gang prevention and intervention strategies. Each of the two applicable records contained a performance plan with a goal related to gang prevention. The program maintains a logbook with the names of the youth who have been identified gang members, their gang affiliation, and a plan to keep conflicting gang members separated.

2.07 R-PACT Assessment and Re-Assessments	Satisfactory Compliance
The program shall ensure an initial assessment of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the initial assessment process in JJIS. The program shall ensure a reassessment of each youth is conducted within ninety days. The program shall ensure any other updates or reassessments are completed when deemed necessary by the intervention and treatment team to effectively manage the youth's case. The program shall maintain all reassessment documentation in the youth's official youth case record.	

The program has a policy and procedures to assess each youth using the Residential Positive Achievement Change Tool (R-PACT) within thirty days of admission. Seven youth case management records were reviewed, and all contained a R-PACT completed within thirty days of the youth admission, as well as re-assessments completed as needed or at ninety-day increments. Each record contained the R-PACT and R-PACT re-assessment, which is also documented and maintained in the Department's Juvenile Justice Information System (JJIS).

2.08 Youth Needs Assessment Summary (YNAS)	Satisfactory Compliance
The program shall ensure a Youth Needs Assessment Summary (YNAS) of each youth is conducted within thirty days of admission. The program shall maintain all documentation of the YNAS.	

The program has a policy and procedures for staff to complete a Youth Needs Assessment Summary (YNAS) for each youth within thirty days of admission. Seven youth case management records were reviewed, and each record contained the YNAS completed within thirty days of the youth's admission. Each YNAS was documented and maintained in the Department's Juvenile Justice Information System (JJIS).

2.09 Performance Plan Development, Goals and Transmittal (Critical)	Satisfactory Compliance
The intervention and treatment team, including the youth, shall meet and develop the performance plan, based on the findings of the initial assessment of the youth, within thirty days of admission. *For each goal, the performance plan shall specify its target date for completion, the youth's responsibilities to accomplish the goal, and the program's responsibilities to enable the youth to complete the goal.* *Within ten working days of completion of the performance plan, the program shall send a transmittal letter and a copy of the plan to the committing court, the youth's juvenile probation officer (JPO), the parent/guardian, and the Department of Children and Families (DCF) counselor, if applicable.*	

The program has a policy and procedures indicating the intervention and treatment team is to meet and develop the performance plan within thirty days of a youth's admission. Seven youth case management records were reviewed. All seven records contained an individualized performance plan (IPP) developed within thirty days of admission. The treatment team members present during the development of the IPP included the treatment team leader, the youth, administrative representative, living unit representative, treatment staff, and education staff. None of the reviewed records reflected youth involvement with the Department of Children and Families (DCF) or Agency for Persons with Disabilities (APD). The interventions the treatment team developed within the IPP are to aide each youth to facilitate successful reintegration into the community upon release from the program. Seven youth records were reviewed, and each performance plans addressed the youth's top three criminogenic needs. All plans contained specific delinquency interventions with measurable outcomes, and court ordered sanctions. Each IPP indicated the youth's responsibility to accomplish the established goals, and the staff's responsibility to enable the youth to complete the goals. Six of seven reviewed IPP's contained target completion dates for goals and objectives. The remaining record did not indicate a start or end date for an employability goal. All seven reviewed IPP's contained at least one transition goal. The program has a policy and procedures to send a transmittal letter and a copy of each youth's IPP within ten working days of completion to the committing court, juvenile probation officer (JPO), the parent/guardian, and the DCF counselor, if applicable. Each record documented the transmittal of the IPP within the required time frame to the committing court, JPO, and parent/guardian. The performance plans were signed by the youth, treatment team leader, and other participants. Six records contained a parent/guardian signature sheet returned to the program. Each record documented a copy of the plan was provided to the youth. Seven

youth were interviewed, and each youth was able to articulate the goals on their IPP, and goals they are currently working on. Each youth reported they have a copy of their IPP.

2.10 Performance Plan Revisions	Satisfactory Compliance
Performance reviews shall result in revisions to the youth's performance plan when determined necessary by the intervention and treatment team.	

The program has a policy and procedures for intervention and treatment team to revise each youth's performance plan, when necessary, based upon the Residential Positive Achievement Change Tool (R-PACT) reassessment results, demonstrated progress or lack of progress towards completing a goal, or newly acquired or revealed information. Performance plan revisions were documented in all seven reviewed youth case management records.

2.11 Performance Summaries and Transmittals	Satisfactory Compliance
The intervention and treatment team shall prepare a Performance Summary at ninety-day intervals, beginning ninety days from the signing of the youth's performance plan, or at shorter intervals when requested by the committing court. *Additionally, the intervention and treatment team shall prepare a performance summary prior to the youth's release, discharge, or transfer from the program.* *The program shall distribute the Performance Summary, as required, within ten working days of its signing.*	

The program has a policy and procedures addressing the intervention and treatment team to prepare a performance summary at ninety-day intervals, beginning ninety days from the signing of the performance plan or at shorter intervals when requested by the committing court. Seven reviewed youth case management records were applicable for the completion of performance summaries. The performance summaries were completed within the required time frames in each record. The performance summaries included all required information including the youth's status on each performance plan goal, overall treatment progress, the youth's current stage of change, academic status, overall behavior adjustment, positive and negative incidents or events, and a justification for request of release, discharge, or transfer, when applicable. The program has a policy and procedures to distribute the performance summary within ten workings days of its signing. All seven records contained documentation showing performance summaries were transmitted to all required parties within ten working days. Each youth was able to add comments to the summaries prior to the transmittal. None of the youth were applicable for a release summary. Seven youth interviewed reported they received a copy of their performance summary sent to the court. A review of four closed records also confirmed the program is distributing the performance summary within ten working days of all required signatures and a release or discharge summary was completed as required.

2.12 Parent/Guardian Involvement in Case Management Services	Satisfactory Compliance
The program shall, to the extent possible and reasonable, encourage and facilitate involvement of the youth's parent/guardian in the case management process.	

The program has a policy and procedures to encourage and facilitate involvement of the youth's parent/guardian in the case management process. The facility administrator was interviewed

and indicated parents/guardians are encouraged to participate in the program through the assessment process, weekly telephone calls, quarterly family days, treatment teams, transitions conferences, and exit conferences. Seven records were reviewed for parent/guardian involvement in case management services. Each record contained documentation reflecting the parents/guardians were contacted and encouraged to participate in quarterly family days, treatment teams, and transition and exit conferences. Performance plans were mailed to parents/guardians with a request for a return signature. There were no treatment teams held during the week of the annual compliance review; therefore, no observation could be made.

2.13 Members of Treatment Team	Satisfactory Compliance
The team includes, at a minimum, the youth, representatives from the program's administration and residential living unit, education, and others responsible for providing or overseeing the provision of intervention and treatment services.	

Within the program, the case managers serve as treatment team leaders. Treatment team members include each youth, case manager, therapist, nurse, representatives from education, administration, and the living unit, as well as the youth's assigned juvenile probation officer (JPO), parent/guardian, or Department of Children and Families (DCF) counselor, when applicable. A review of seven youth case management records confirmed all treatment team members participated in the treatment team meetings. Telephone calls were made to parents/guardians and JPOs to facilitate their participation. If no one was reached by phone, the notice was listed on the treatment team signature page and follow up was attempted.

2.14 Incorporation of Other Plans Into Performance Plans	Satisfactory Compliance
The youth's performance plan shall reference or incorporate the youth's treatment or care plan.	

The program has a policy and procedures for the intervention and treatment team to reference or incorporate each youth's treatment plan into the youth's performance plan. Seven youth case management records were reviewed and all performance plans contained documentation of incorporation of mental health treatment and education plans, as well as, transitional goals throughout the youth's stay.

2.15 Treatment Team Meetings (Formal and Informal Reviews)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team meets every thirty days to review each youth's performance, to include R-PACT reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment progress. *A residential commitment program shall ensure the intervention and treatment team reviews each youth's performance, including R-PACT reassessment results, progress on individualized performance plan goals, positive and negative behavior, including behavior resulting in physical interventions. If the youth has a treatment plan, review their treatment progress.*	

The program has a policy and procedures for the intervention and treatment team to meet every thirty days to review each youth's performance, including a review of the Residential Positive Achievement Change Tool (R-PACT) reassessment results, progress on individual performance plan goals, positive and negative behavior, and individualized treatment plan. There were no

treatment teams held during the week of the annual compliance review; therefore, no observations could be made. Seven youth case management records were reviewed. Formal treatment team meetings were held every thirty days. Treatment team members participated or provided written input prior to meetings in the seven reviewed records. Documentation indicated parents/guardians and the assigned juvenile probation officer were invited to participate in the treatment team meetings. The treatment team leader followed up as required for individuals who could not participate. Seven youth were interviewed, and each youth indicated they are able and do demonstrate skills they have learned during the treatment team meeting. All seven youth stated staff review their performance during treatment team including addressing their progress on goals, positive and/or negative behavior, and treatment progress. The intervention and treatment team leader also meet with each youth to conduct bi-weekly informal meetings to review performance including a review of the Residential Positive Achievement Change Tool (R-PACT) reassessment results, progress on individual performance plan goals, positive and negative behavior, and youth's individualized treatment plan. Each reviewed record contained the required informal treatment team meetings documented within the correct time frame.

2.16 Career Education	**Satisfactory Compliance**
Staff shall develop and implement a vocational competency development program.	

The program has a policy and procedures for the career education of the youth while in the program. A review of four closed records reflected three of the four records contained a sample employment application and four records contained a résumé included in the closed record. Three of the four records contained appropriate documents essential to obtaining employment and documentation the youth's parent/guardian and juvenile probation officer (JPO) were aware of the vocational plan for the youth. One record did not include all required components due to the youth being moved for further placement, as the youth was deemed to be a sexually violent predator and was moved to a civil commitment. Career courses are available, as well as life skills classes such as completing a tax return, check writing, and employment applications. Career Source appointments are mentioned if the appointment has not been made. Career education is supervised by the Volusia County School Board. An interview with the lead teacher indicated training includes Microsoft Office certification and digital information technology.

2.17 Educational Access	**Satisfactory Compliance**
The facility shall integrate educational instruction (career and technical education, as well as academic instruction) into their daily schedule in such a way ensuring the integrity of required instructional time.	

The program has a policy and procedures for the youth to attend educational instruction daily. The program provides 250 days of instruction with a minimum of twenty-five hours of instruction weekly. The program uses ten or less days for teacher planning and/or training. Four closed records were reviewed, and each record indicated the youth regularly attend education while in the program. An interview with the lead educator indicated the educational schedule is adhered to with very little or no interference of the school programing. The youth receive credits for their completed educational/career work. Seven interviewed youth indicated there is minimal interference during educational times.

2.18 Education Transition Plan	Satisfactory Compliance
Staff and youth complete an education transition plan upon entry including provisions for continuation of education and/or employment.	

The education staff and case managers work together to develop each youth's transition plan, which is developed during the transition conference. Four closed records contained a transition plan with education requirements documented. In each record the transition plan was developed with the youth, program, education, and aftercare staff with specific plans for the continuation of education and/or employment. The education transition plans included services and interventions based on the youth's educational needs, post-release education plans, the recommended educational placement, and monitoring responsibilities by individuals responsible for the reintegration and coordination of support services. The educational staff also initiate the first part of the Electronic Educational Exit Plan (EEEP) in the Department's Juvenile Justice Information System (JJIS) which notifies a youth's home school district of continuing education plans. The youth's community school district completes a section of the EEEP to let the program know of possible school placements in a youth's resident county to ensure a seamless transition. All four closed records reflected evidence the parent/guardian was aware of the overall transition plan. One youth did not obtain a Florida identification card since he was relocating to another state. Each record contained appropriate documents essential for the youth to obtain employment upon leaving the program, as well as, a résumé summarizing education, work experience, and/or career training. The youth had appointment calendars which reflect certain appointments were not pre-scheduled and would require being made after the youth was released.

2.19 Transition Planning, Conference, and Community Re-entry Team Meeting (CRT)	Satisfactory Compliance
A residential commitment program shall ensure the intervention and treatment team is planning for the youth's successful transition to the community upon release from the program, when developing each youth's performance plan and throughout its implementation during the youth's stay. *During the transition conference, participants shall review transition activities on the youth's performance plan, revise them if necessary, and identify additional activities/services as needed. Target completion dates and persons responsible for their completion shall be identified during the conference. The intervention and treatment team leader shall obtain conference attendees' dated signatures, representing their acknowledgement of the transition activities and accountability for their completion pursuant to the youth's performance plan.* *Each youth must attend their scheduled Community Re-entry Team (CRT) meeting prior to discharge.*	

One open record and four closed records were reviewed for transition planning and conference, and community re-entry team meetings. Each record documented a transition conference was held at least sixty days prior to the youth's anticipated release date. Transition plans were developed during the transition conferences. Each transition plan included appropriate goals and start/end dates for the youth's release back into the community. Administrative staff participated and signed the transition paperwork. The records documented all required parties were invited to participate, with the parent/guardian and assigned juvenile probation officer (JPO) participating by phone. When parents/guardians or JPOs were not available, the transition plan was forwarded to them. The program has a process for updating projected

release dates in the Department's Juvenile Justice Information System (JJIS). The program did not have evidence of community re-entry meetings in the closed records but was able to provide separate documentation the case manager and youth attended the CRT's. The CRTs were held between the transition conference and exit staffing.

2.20 Exit Portfolio	Satisfactory Compliance
The residential commitment program will assemble an exit portfolio for each youth to assist the youth once he/she is released back into the community.	

Documents for the exit portfolio are maintained in educational and case management records. Four closed education and case management records were reviewed for the exit portfolio. The program provided a sample of youth obtaining their state identification cards prior to release, although the parent/guardian in each case had agreed to assist the youth in gaining their Florida identification (ID) upon return to the home community. Each of the four closed records contained the transition plans, a calendar of appointments, and résumé. All four records contained a sample job application, as well as any vocational certificates earned in the program and educational records. Two of the four records contained the youth's Social Security card and birth certificate. Each record documented the youth's exit portfolio was verified at the exit conference. There was documentation the exit portfolios were sent to the youth's juvenile probation officer and provided to the youth upon release.

2.21 Exit Conference	Satisfactory Compliance
An exit conference shall be conducted, in addition to a formal or informal meeting, to review the status of goals developed at the transition conference and finalize release plans.	

Four closed records were reviewed for exit conferences. All four exit conferences were held at least fourteen days prior to release. Each exit conference was documented in the case record, including the date, signatures (names if by telephone), and a summary of pending transition goals. Documentation reflected the youth's admission date and date of termination in the case record matched dates in the Department's Juvenile Justice Information System (JJIS). All four records documented all required parties attended the exit conferences or provided written input prior to the conferences. Each record documented attempts to reach parents/guardians and the juvenile probation officer (JPO) by telephone at the time of the exit conference. All records documented the exit conferences were held after the community re-entry team (CRT) meetings and were held separate from the CRT.

Standard 3: Mental Health and Substance Abuse Services

Overview

The program's mental health staff consists one licensed clinical director and three full time non-licensed therapists. The DMHCA provides clinical supervision for the four non-licensed therapists. The program contracts with a licensed psychiatrist. The psychiatrist provides psychopharmacological services, treatment recommendations, and follow-up supervision of all youth prescribed psychotropic medications. The DMHCA and the psychiatrist are available twenty-four hours a day, seven days a week. All applicable program staff received the minimum hours of required training related to mental health and substance abuse.

3.01 Designated Mental Health Clinician Authority or Clinical Coordinator	Satisfactory Compliance
Each program director is responsible for the administrative oversight and management of mental health and substance abuse services in the program. *Programs with an operating capacity of 100 or more youth, or those providing specialized treatment services, must have a single licensed mental health professional designated as the Designated Mental Health Clinician Authority (DMHCA) who is responsible for the coordination and implementation of mental health and substance abuse services in the facility/program.* *Programs with an operating capacity of fewer than 100 youth or those not providing specialized treatment services, may have either a DMHCA or a Clinical Coordinator.*	

The program provides sex offender treatment services and has a single licensed mental health professional who serves as the designated mental health clinical authority (DMHCA). The DMHCA is responsible for the coordination and implementation of mental health and substance abuse services in the program. The DMHCA is a licensed mental health counselor (LMHC) who has a clear and active license to practice in the State of Florida. The DMHCA is on-site forty hours a week. The DMHCA is responsible for the supervision of four non-licensed treatment staff. An interview with the DMHCA confirmed the role of the DMHCA is to provide clinical supervision to the non-licensed therapists, and to ensure appropriate coordination, implementation and oversight of mental health and substance abuse services.

3.02 Licensed Mental Health and Substance Abuse Clinical Staff (Critical)	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program has a psychiatrist who specializes in child and adolescent psychiatry. The psychiatrist provides eight hours of service on a bi-weekly basis. The program's designated mental health clinical authority (DMHCA) is a licensed mental health counselor (LMHC) pursuant to Chapter 491, F.S. The psychiatrist and the DMHCA are licensed to practice treatment services in the State of Florida. A review of their licenses found each was clear and active. The LMHC is qualified to provide juvenile sex offender therapy.

3.03 Non-Licensed Mental Health and Substance Abuse Clinical Staff	Satisfactory Compliance
The program director is responsible for ensuring mental health and substance abuse services are provided by individuals with appropriate qualifications. Clinical supervisors shall ensure clinical staff working under their supervision are performing services they are qualified to provide based on education, training, and experience.	

The program ensures mental health and substance abuse services are provided by individuals with appropriate qualifications. The program has three full-time and one-part time non-licensed clinical staff. A review of the clinical supervision log confirmed all non-licensed therapists receive a minimum of one hour a week of on-site face-to-face direct supervision from the designated mental health clinician authority (DMHCA), who is a licensed mental health counselor (LMHC). The four non-licensed clinical staff are performing services which they are qualified to provide based on education, training, and experience. Each of the non-licensed clinical staff has a master's-level degree from an accredited university or college in the field of counseling, social work, psychology, or related human services field. The non-licensed clinical staff provide substance abuse services under Chapter 397, F.S. Three of the non-licensed clinical staff received twenty hours of training and supervised experience in assessing suicide risk; a part time non-licensed clinical staff member is new to the position is not trained to assess youth for suicide risk. The non-licensed clinical staff also received mental health crisis intervention and emergency mental health services training.

3.04 Mental Health and Substance Abuse Admission Screening	Satisfactory Compliance
The mental health and substance abuse needs of youth are identified through a comprehensive screening process ensuring referrals are made when youth have identified mental health and/or substance abuse needs or are identified as a possible suicide risk.	

The program has a policy and procedures for mental health and substance abuse admission screenings. The Massachusetts Youth Screening Instrument - Second Version (MAYSI-2) is used for admission screenings. Seven treatment records were reviewed. Each record contained a MAYSI-2 completed on the admission date. The MAYSI-2 was administered by the designated mental health clinician authority (DMHCA) and three treatment staff members trained to conduct the screening. All records indicated a referral for a comprehensive evaluation based on the MAYSI-2 results and the youth's mental health history. All records indicated a referral for the administration of an Assessment of Suicide Risk (ASR), with one youth identified as at risk of suicide based on the MAYSI-2 results. The program completes an ASR during the intake process for each youth admitted to the program, regardless of elevated suicide risk factors. Based on the facility administrator's interview, the facility administrator indicated both the MAYSI-2 and a clinical screening are utilized to identify youth at risk for mental health, substance abuse, and suicide. Clinical screenings include the trauma symptom checklist and inventory.

3.05 Mental Health and Substance Abuse Assessment/Evaluation	Satisfactory Compliance
Youth identified by screening, staff observation, or behavior after admission as in need of further evaluation must be referred for a Comprehensive Mental Health Evaluation and/or Comprehensive Substance Abuse Evaluation or Updated Evaluation.	

The program has a policy and procedures for mental health and substance abuse assessment and evaluation. Seven records were reviewed, and all had new mental health and substance abuse evaluations completed within thirty calendar days of admission. Two of the seven comprehensive mental health and substance abuse evaluations were completed by a licensed mental health clinician. The other five evaluations were completed by a non-licensed mental health clinical staff and were reviewed and signed by the licensed mental health counselor.

3.06 Mental Health and Substance Abuse Treatment	Satisfactory Compliance
Mental health and substance abuse treatment planning in Departmental facilities focuses on providing mental health and/or substance abuse interventions and treatment to reduce or alleviate the youth's symptoms of mental disorder and/or substance abuse impairment and enable youth to function adequately in the juvenile justice setting. *The treatment team is responsible for assisting in developing, reviewing, and updating the youth's individualized and initial mental health/substance abuse treatment plans.*	

The program has a policy and procedures for treatment services. Seven youth records were reviewed. All seven records indicated a need for mental health and substance abuse treatment and/or education. All youth were assigned to a multidisciplinary treatment team at intake. The multidisciplinary treatment team consists of a residential living unit representative, the parent/guardian, education representative, administration staff representative, substance abuse/mental health staff, and medical staff. The seven youth records indicated individual, group, and family counseling are provided in accordance with each youth's initial and individualized mental health and substance abuse treatment plans. A review of group sign-in sheets for mental health groups indicated groups are limited to ten or fewer youth. Substance abuse groups are limited to fifteen or fewer youth. All mental health and substance abuse services are provided by a licensed mental health professional, three full-time, and one-part time mental health clinical staff. Seven interviewed direct care staff members indicated they never facilitate any mental health or substance abuse groups. A treatment team meeting was not held during the annual compliance review week; therefore, it could not be observed. Seven youth interviews confirmed each is participating in groups to include juvenile sex offender therapy, group therapy, anger management, substance abuse, and various delinquency interventions. An interview with the designated mental health clinical authority (DMHCA) indicated juvenile sex offender specific group sessions, clinical group services, family sessions, and individual therapy sessions are conducted at the program.

3.07 Treatment and Discharge Planning (Critical)	Satisfactory Compliance
Youth determined to have a serious mental disorder or substance abuse impairment, and are receiving mental health or substance abuse treatment in a program, shall have an initial or individualized mental health or substance abuse treatment plan. When mental health or substance abuse treatment is initiated, an initial or individualized mental health or substance abuse treatment plan is completed. *All youth who receive mental health and/or substance abuse treatment while in a residential program shall have a discharge summary completed documenting the focus and course of the youth's treatment and recommendations for mental health and/or substance abuse services upon youth's release from the facility.*	

The program has a policy and procedures for treatment and discharge planning. Seven youth records were reviewed. Each contained an initial treatment plan completed on the Department's MHSA 015 form. The plans had all the required elements and were signed within seven days of treatment by the licensed mental health/substance abuse clinical staff. The seven initial treatment plans included the youth's psychiatric needs. Four of seven youth records indicated continuation of prescribed psychotropic medication. The four youth on psychotropic medications had an initial treatment plan which contained documentation of the psychiatrist monitoring the prescribed psychotropic medication, to include the frequency of the monitoring. Initial treatment notes were completed and signed by the licensed mental health/substance abuse clinical staff. All seven youth records contained an individual mental health/substance abuse treatment plan, which were signed by the licensed mental health/substance abuse clinical staff. The individual mental health/substance abuse treatment plans reviewed contained all elements of the Department's MHSA 016 form.

Three closed records were reviewed for discharge planning. Each closed record had a discharge plan on a form which contained all the elements on the Department's MHSA 011 form. None of the closed youth records were applicable for a suicide risk alert or notification of suicide to the parent/guardian. The three discharge plans contained services needed for daily maintenance of the positive improvement in behavioral, emotional, and social skills made by youth during treatment. The discharge plans were discussed with the youth, parent/guardian, and juvenile probation officer (JPO) by phone during the exit conference. All closed records indicated the mental health/substance abuse treatment discharge summary was provided to the youth, JPO, and the parent/guardian.

3.08 Specialized Treatment Services (Critical)	Satisfactory Compliance
Specialized treatment services shall be provided in programs designated as "Specialized Treatment Services Programs" or are designated to provide "Specialized Treatment Overlay Services.".	

The program provides juvenile sex offender treatment services for all youth. Treatment services are provided in accordance with Florida Statute, Administrative Rule, 63N-1, F.A.C., and the provider's contract. The juvenile sex offender treatment services are conducted, managed, and supervised in accordance with Section 490.012(8) or 491.012(1)(n). F.S. Sex offender treatment services are facilitated by the licensed therapist. Educational groups are provided by qualified non-licensed therapists. An interview with the facility administrator confirmed the program provides juvenile sex offender specific group services. Groups provided by the program include Pathways and Living in Balance. The licensed therapist conducts fidelity monitoring of all mental health, substance abuse, and sex offender services.

3.09 Psychiatric Services (Critical)	Satisfactory Compliance
Psychiatric services include psychiatric evaluation, psychiatric consultation, medication management, and medical supportive counseling provided to youth with a diagnosed DSM-IV-TR or DSM-5 mental disorder and each youth receiving psychotropic medication in the program as set forth in Rule 63N-1, F.A.C.	

The program has a policy and procedures for providing psychiatric services. Psychiatric services are provided by a licensed psychiatrist. The psychiatrist is licensed under Chapter 459. Seven youth records were reviewed. The psychiatrist is on-site bi-weekly for four hours. Four of seven youth records indicated the youth entered the program on prescribed psychotropic medication. All initial psychiatric interviews included elements specific to the Rule 63N-1 and occurred within fourteen days of admission. The four youth identified at intake as entering the program on prescribed psychotropic medication received a psychiatric evaluation within thirty days. Medication monitoring is conducted by the psychiatrist every thirty days. Each youth on psychotropic medication had a signed Authority for Evaluation and Treatment (AET) on record. None of the youth psychotropic medications were newly prescribed at the program, discontinued, or had a significant drug dosage change at the program. The program does not utilize an advanced registered nurse practitioner (ARNP). Consent for all new medications prescribed by the psychiatrist was obtained for each youth.

3.10 Suicide Prevention Plan (Critical)	Satisfactory Compliance
The program follows a suicide prevention plan to safely assess and protect youth with elevated risk of suicide in the least restrictive means possible, in accordance with the Rule 63N-1, Florida Administrative Code.	

The program has a comprehensive suicide prevention plan. The plan provides procedures for identifying youth at risk of suicide. All youth who scoring summary indicates the youth is at risk of suicide on the Massachusetts Youth Screening Instrument – Second Version (MAYSI-2) and/or has a recent history of placement on suicide precautions are referred for an Assessment of Suicide Risk (ASR). All youth assessed as at risk for suicide are placed on the alert board and an alert is entered in the Department's Juvenile Justice Information System (JJIS). Youth are placed on suicide precautions until an ASR is administrated. When a youth is continued on suicide precautions, there are procedures for administering a follow-up ASR. The program's suicide prevention plan describes the levels of supervision for youth on suicide precautions. The levels are one-to-one supervision, constant sight and sound supervision, close supervision, and standard supervision. The program does not use secure observation. The program utilizes the Protective Action Response (PAR) escalation matrix, when youth are in crisis or harming themselves. Placement of youth on suicide precautions is communicated through logbook entries and an internal alert form, which documents the individuals notified of the youth's status. The facility administrator or designee and the licensed mental health counselor reviews all ASR documentation.

3.11 Suicide Prevention Services (Critical)	Satisfactory Compliance
Suicide Precautions are the methods utilized for supervising, observing, monitoring, and housing youth identified through screenings, available information, or staff observations as having suicide risk factors. *Any youth exhibiting suicide risk behaviors shall be placed on Suicide Precautions (Precautionary Observation or Secure Observation), and a minimum of constant supervision.* *All youth identified as having suicide risk factors by screening, information obtained regarding the youth, or staff observations shall be placed on Suicide Precautions and receive an Assessment of Suicide Risk.*	

The program has a policy and procedures for suicide prevention services. The policy includes a review process for every serious suicide attempt or serious self-inflicted injury (requiring hospitalization or medical attention) and a mortality review for a completed suicide. The review includes the circumstances surrounding even, program procedures relevant to the incident, all relevant training received by involved staff, pertinent medical and mental health services involving the victim, possible precipitating factors, and recommendations, if any, for changes in policy, training, physical plant, medical or mental health services, and/or operational procedures.

Seven youth records were reviewed. Four of the seven records required precautionary observation placements. A Juvenile Justice Information System (JJIS) suicide alert was initiated for each youth. Each youth remained on precautionary observation until an Assessment of Suicide Risk (ASR) or Follow-Up ASR was completed. Documentation of observations are done in real time. Each initial ASR was completed within twenty-four hours and administered by the licensed mental health counselor (LMHC) or the non-licensed mental health clinical staff working under the direct supervision of the LMHC. Each ASR was signed by the LMHC. When the ASR indicated discontinuation of suicide precautions, youth were not transitioned to a lower level of supervision until the non-licensed mental health clinical staff person conferred with both the LMHC and the facility administrator. The actual date/time the clinician conferred with facility administrator and licensed mental health professional was recorded on the ASR in the date/time sections. When Follow-Up ASRs indicated suicide precautions may be discontinued, youth were stepped down to close supervision prior to transition to a normal routine and standard supervision. The youth's juvenile probation officer and the parent/guardian were notified of the youth's potential suicide risk. Logbook documentation coincided with precautionary observation logs and the ASRs. Training records confirmed non-licensed mental health staff have the appropriate training to complete ASRs. Training documentation indicated staff are trained and prepared to respond to youth who express suicide ideations. Seven staff interviews indicated knowledge of the locations of the suicide response kits. The staff interviews also indicated staff would notify mental health staff, search the youth and the youth's room for any sharps, maintain constant sight and sound supervision, and document supervision for youth on precaution observation.

3.12 Suicide Precaution Observation Logs (Critical)	Satisfactory Compliance
Youth placed on suicide precautions shall be maintained on one-to-one or constant supervision. The staff member assigned to observe the youth shall provide the appropriate level of supervision and record observations of the youth's behavior at intervals of thirty minutes, at a minimum.	

The program has a policy and procedures for completing suicide precaution logs. The program reported four suicide alerts during the annual compliance review period. The records were reviewed for suicide precaution observation logs. All logs were maintained for the duration of the suicide precaution period. Suicide precaution observation logs documented staff observations of each youth's behavior in real time, and at thirty-minute intervals. Logs were reviewed and signed by each shift supervisor at the end of their shift and mental health clinical staff daily. One of four suicide precaution observation logs indicated warning signs of risk were observed. A notification was not made to the mental health clinical staff. The youth on suicide precaution displayed warning signs of crying and sadness. The warning signs were noted on the suicide precaution observation log, but staff failed to notify mental health staff and the shift supervisor. Corrective action was taken by the licensed mental health counselor immediately addressing the failure with a case manager and a shift supervisor. The staff received a coaching session with the licensed mental health counselor. Interviews with youth who had been placed on precautionary observations revealed staff were with them at all times; they were never left alone.

3.13 Suicide Prevention Training (Critical)	Satisfactory Compliance
All staff who work with youth shall be trained to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions.	

The program has a policy and procedures for staff to complete training on how to recognize verbal and behavioral cues indicating suicide risk, suicide prevention, and implementation of suicide precautions. Each of the five clinical staff training records found staff completed six hours of suicide prevention and implementation of suicide precautions training. The program conducts mock mental health, suicide and emergency drills quarterly for direct care staff. The drills also include cardiopulmonary resuscitation/ automated external defibrillator (CPR/AED) demonstrations. The most recent drills were conducted on June 27, July 26, and September 1, 2018. Drills are conducted on all shifts. Staff not available to participate in mock drills are provided training on the mock drills during the all campus staff meeting by the licensed mental health counselor.

3.14 Mental Health Crisis Intervention Services (Critical)	Satisfactory Compliance
Every program shall respond to youth in crisis in the least restrictive means possible to protect the safety of the youth and others, while maintaining control and safety of the facility. The program shall be able to differentiate a youth who has an acute emotional problem or serious psychological distress from one who requires emergency services. A youth in crisis does not pose an imminent threat of harm to himself/herself or others which would require suicide precautions or emergency treatment.	

The program has a mental health crisis intervention services plan which lists the response to a youth in crisis utilizing the least restrictive means. The plan includes the Protective Action Response (PAR) escalation matrix for responding to crisis events. Staff document internal alerts and enter the alerts in the Department's Juvenile Justice Information System (JJIS). The same

information is documented on the alert board located in the staff's debriefing room. The plan has three levels of supervision which include one-to-one supervision, constant supervision, and close supervision. The youth's status is recorded in the logbook and on the alert board. The information is shared during shift meetings and documented on a shift report. The facility administrator, the designated mental health clinician authority, and the management team review all crisis events.

3.15 Crisis Assessments (Critical)	Satisfactory Compliance
A Crisis Assessment is a detailed evaluation of a youth demonstrating acute psychological distress (e.g., anxiety, fear, panic, paranoia, agitation, impulsivity, rage) conducted by a licensed mental health professional, or by a non-licensed mental health clinical staff person working under the direct supervision of a licensed mental health professional, to determine the severity of youth's symptoms, and level of risk to self or others. When staff observations indicate a youth's acute psychological distress is extreme/severe and does not respond to ordinary intervention, the program director or designee shall be notified of the crisis situation and need for crisis assessment. A Crisis Assessment is to be utilized only when the youth's crisis (psychological distress) is not associated with suicide risk factors or suicide risk behaviors. If the youth's behavior or statements indicate possible suicide risk, the youth must receive an Assessment of Suicide Risk instead of a Crisis Assessment.	

The program has a policy and procedures for crisis assessments. No crisis assessments were completed during this review period or in the last twelve months. Training documentation, the program's crisis assessment tool, and the program's policy confirms implementation of crisis assessments. The crisis assessment form utilized by the program includes all the information from the Department's Mental Health Substance Abuse 023 form. The assessment includes the reason for the assessment, mental status examination and interview, determination of danger to self/others, and initial clinical impression. The assessment also includes the supervision recommendations, treatment recommendations, recommendations for follow-up or further evaluation, and notification to parent/guardian of follow-up treatment.

3.16 Emergency Mental Health and Substance Abuse Services (Critical)	Satisfactory Compliance
Youth determined to be an imminent danger to themselves or others due to mental health and substance abuse emergencies occurring in facility require emergency care provided in accordance with Rule 63N-1 Florida Administrative Code and the facility's emergency care plan.	

The program has an emergency mental health and substance abuse plan. The emergency mental health and substance abuse plan includes procedures for mental health or substance abuse emergencies. All staff are authorized to call 9-1-1 for emergency services. The plan includes all the required elements to include staff immediate response, notification requirements, communication, supervision, authorization to transport for Baker/Marchman Acts, documentation, training, and a review process. Staff are required to complete suicide precaution observation logs when youth are placed on emergency mental health and substance abuse status. Incidents are recorded in the logbook and on a mental health referral form. Incidents are recorded on the shift reports and on the alert board. The facility administrator or designee is responsible for notifying the youth's parent/guardian and the juvenile probation officer. The program training for emergency mental health and substance abuse services include recognizing the signs and symptoms of an emergency mental health and substance abuse events. The emergency mental health and substance abuse plan review process is the same as outlined in the suicide prevention plan and the crisis intervention plan. The facility administrator,

designated mental health clinician authority, and the management team meet to review all incidents and determine corrective action as needed.

3.17 Baker and Marchman Acts (Critical)	Non-Applicable
Individuals who are believed to be an imminent danger to themselves or others because of mental illness or substance abuse impairment require emergency mental health or substance abuse services.	

The program did not utilize a Baker Act or Marchman Act procedure during this review period; therefore, this indicator rates as non-applicable.

Standard 4: Health Services

Overview

The program employs a full-time registered nurse (RN), a full-time licensed practical nurse (LPN), a part-time LPN, and pro re nata (PRN) RN. The full-time RN serves as the health services administrator (HSA), overseeing all clinic operations. The current HSA has been with the program just over a month. A regional nurse has provided coverage at the program during the annual compliance review period. The HSA is on-site at least forty hours a week and is on call twenty-four hours a day, seven days a week. Nursing staff complete initial screenings, review youth history and records upon admission, provide orientation to healthcare services for newly admitted youth, conduct sick call, administer medication, make referrals, schedule periodic evaluations and follow-up care, and maintain inventories for medications and sharps.

The program contracts with an osteopathic physician (DO) to serve as the designated health authority (DHA). The DHA oversees all health-related services provided at the program, to include but not limited to, the review of medical policies and procedures, review of youth healthcare records and care provided, completion of Comprehensive Physical Assessments, and follow-up care. There is a contract in place with another DO to provide coverage for the DHA if he is unable to be at the program. The program also contracts with a psychiatrist, who completes psychiatric evaluations, prescribe psychotropic medication as needed, and monitor youth on psychotropic medication. The program has an agreement with a dentist for dental care, which is provided off-site at the dentist's office. The program has an agreement with an optometrist, who conducts vision exams at the program. Vision and dental appointments are scheduled, as needed, for each youth.

The program has a modified Institutional Class II Type B pharmacy permit. A consultant pharmacist visits the program monthly to review medications. Human immunodeficiency virus (HIV) education, testing, and pre-test and post-test counseling are provided on-site. Youth are taken off-site to the local health department for immunizations, if needed.

4.01 Designated Health Authority/Designee (Critical)	Satisfactory Compliance
The Designated Health Authority (DHA) shall be clinically responsible for the medical care of all youth at the facility.	

There is a contract in place with a licensed osteopathic physician (DO) to serve as the designated health authority (DHA). The DHA has specialty training in family medicine. The DO has a clear and active license in the State of Florida with a license expiration date of March 31, 2020. The contract requires the DHA be on-site at least two hours a week and available for consult twenty-four hours a day, seven days a week. The contract outlines services to be provided. The program also contracts with another DO to cover for the DHA when on scheduled leave or otherwise not available. The DO providing coverage also has specialty training in family medicine. Sign-in logs showed the DHA or DO who provides coverage has been on-site weekly for the past six months. There was one instance of ten days between DHA visits. The DHA attends quarterly meetings with the facility administrator, health services administrator (HSA), and the pharmacy consultant. An interview with the DHA and review of seven youth records and other documentation confirmed the DHA provides oversight for all healthcare provided for youth at the program.

4.02 Facility Operating Procedures	Satisfactory Compliance
The program shall have Facility Operating Procedures (FOP) for all health-related procedures and protocols utilized at the facility.	

Medical policies, procedures, and protocols were reviewed and signed by the designated health authority (DHA) and the previous facility administrator in July 2018. The new facility administrator, who started at the program in September 2018, signed the medical policies and procedures shortly after their arrival. Each individual policy and procedure was signed by the DHA and the facility administrators. In July and August 2018, all medical staff signed cover pages to acknowledge an annual review of the medical policies, procedures, and protocols. The psychiatrist signed policies and procedures related to psychiatric care and psychotropic medication monitoring, as well as, signed the cover page acknowledging all medical policies and procedures.

The provider has developed an orientation for newly hired medical staff, which is provided by medical staff and includes a review of the Department's healthcare policies and procedures. The program had one newly hired nurse in the past year and documentation showed the nurse completed the orientation.

4.03 Authority for Evaluation and Treatment	Satisfactory Compliance
Each program shall ensure the completion of the Authority for Evaluation and Treatment (AET) authorizing specific treatment for youth in the custody of the Department.	

Seven youth healthcare records were reviewed for Authority for Evaluation and Treatment (AET) forms. One youth was nineteen years old and did not require an AET. The six applicable records contained a valid AET signed by a parent/guardian. Each AET was a copy and appropriately labeled as a copy. The interview with the nurse showed he was familiar with the process of obtaining an AET. The nurse reported when a youth turns eighteen, a release of information form is completed, and consent is done by the youth for each individual treatment, which was evident in the record reviewed for the youth who were eighteen years of age or older. An AET was obtained for each youth reviewed prior to medical services being provided.

4.04 Parental Notification	Satisfactory Compliance
The program shall inform the parent/guardian of significant changes in the youth's condition and obtain consent when new medications and treatments are prescribed.	

Seven youth healthcare records were reviewed for parental notifications. One youth was nineteen years old and was able to consent to care. The program completed the notifications for this youth, having the youth sign the notification to show consent. The remaining six records included fifty-six parental notifications for health-related care. Requests for consent to off-site dental care and administration of over-the-counter medication in accordance with protocols were documented in each record. Documentation showed written parental notifications were completed whenever youth were prescribed new medication, received off-site care, received periodic evaluations for chronic conditions, saw the dentist or optometrist, or received episodic or emergency care. Telephone contacts or attempted telephone contacts with parents/guardians were documented for emergency care. Telephone notification was completed for new medications in four of five applicable cases. In the remaining case, the written notification was

completed and returned signed by the youth's parent/guardian. A witness was documented for each notification completed by phone. The interview with the nurse showed he knew parental notification requirements.

4.05 Notification – Clinical Psychotropic Progress Note	Satisfactory Compliance
The program shall inform the parent/guardian and obtain consent for the prescription of new psychotropic medications, discontinuances, or psychotropic medication adjustments.	

Six of the seven healthcare records reviewed were applicable for youth taking psychotropic medication. An Acknowledgement of Receipt of Clinical Psychotropic Progress Note (CPPN) along with page three of the CPPN was sent to the parent/guardian each time psychotropic medication was initiated, adjusted, or discontinued. For new psychotropic medication, the notice is sent by certified mail. Psychotropic medications are not initiated until written consent from the parent/guardian is obtained, which was confirmed in records reviewed. Notifications were sent along with page three of the CPPN for monthly medication monitoring as well. The interview with the nurse confirmed written consent is required prior to initiating new psychotropic medication. The nurse also knew notification requirements for when psychotropic medications are adjusted or discontinued.

4.06 Immunizations	Satisfactory Compliance
All youth's immunization history and status shall be verified to meet state and department requirements, and subsequently provide necessary immunizations/vaccinations (with parent/guardian consent).	

The program has a policy and procedures addressing immunizations for youth when the need is identified. The nurse interview indicated youth are sent to the health department for immunizations when needed. A review of seven youth healthcare records found immunizations were reviewed by nursing staff upon admission in each case. The initial progress note completed by the nurse conducting the medical intake indicated each youth's immunizations were current. The regional nurse, who has been providing nursing oversight and coverage at the program, reported no youth have needed immunizations during annual compliance review period.

4.07 Healthcare Admission Screening Form (Facility Entry Physical Health Screening Form)	Satisfactory Compliance
Youth are screened upon admission for healthcare concerns that may need a referral for further assessment by healthcare staff.	

Seven youth healthcare records were reviewed for the completion of Facility Entry Physical Health Screening (FEPHS) forms. A FEPHS form was completed by a nurse on the date of admission in each record. All sections of the FEPHS form and the body chart were thoroughly completed. The nurse was interviewed and confirmed the process for the completion of the FEPHS at the time of admission.

4.08 Medical Alerts	Satisfactory Compliance
Staff shall be alerted of medical issues that may affect the security and safety of the youth in the facility.	

The program maintains an alert list identifying alert information for all youth. Side effects and precautions for medication are listed on medication administration records (MARs) for each youth. Dietary alerts are provided to the food service provider. A review of seven youth healthcare records found alerts in the records were accurately identified on the alert list and the Department's Problem Lists were updated to reflect current alerts. A review of alerts in the Department's Juvenile Justice Information System (JJIS) for all youth in the program found there were only two discrepancies between the alert list and JJIS, both of which were immediately corrected. Only nursing staff can update medical alerts. Seven interviewed staff indicated they are informed of the youth's mental health, medical, and security alerts during staff briefing, by reviewing the program's alert board, and by conducting a logbook review.

4.09 Youth Orientation to Healthcare Services	Satisfactory Compliance
All youth shall be oriented to the general process of health care delivery services at the facility.	

The program has developed a healthcare orientation packet to review with youth upon admission. The orientation packet addresses all required elements for healthcare orientation, to include how to access sick call, medical emergencies, medication administration, and instructions to notify staff of any chest pain, shortness of breath, or other similar difficulties. Youth are also informed of what to do in the event of a sexual assault or attempted sexual assault, the right to refuse care, and the non-disciplinary role of healthcare staff. Seven youth healthcare records were reviewed. Each record documented a nurse reviewed the healthcare orientation packet with the youth on the day of admission. Youth acknowledged the healthcare orientation by signature.

4.10 Designated Health Authority (DHA)/Designee Admission Notification	Satisfactory Compliance
A referral to the facility's Physician, PA, or ARNP shall be made for youth who are admitted with known or suspected chronic conditions not requiring emergency treatment on admission.	

A review of seven youth healthcare records found the designated health authority (DHA) was notified of each youth's admission, as it is the program's practice to notify the DHA of each youth's admission, regardless of their condition(s). The notification was completed by the nurse conducting the medical intake and it was documented in the initial progress note. The notification did document if the youth had any chronic conditions and/or if the youth was taking medications. The psychiatrist was notified if a youth was on psychotropic medication.

4.11 Healthcare Admission Rescreening	Satisfactory Compliance
A Healthcare Admission Rescreening shall be completed each time the physical custody of the youth changes and they are subsequently returned or readmitted to the facility.	

The nurse reported there have been no youth with a change in custody during the annual compliance review period. The program has a policy and procedures requiring the completion of an admission healthcare screening anytime a youth has a change in custody and returns to the facility. The interview with the nurse revealed he knew the policy.

4.12 Health-Related History	Satisfactory Compliance
The standard Department Health-Related History (HRH) form shall be used for all youth admitted into the physical custody of a DJJ facility.	

Seven youth healthcare records were reviewed for a Health-Related History (HRH) form. A new (HRH) completed by a nurse on the date of admission was in each record. The interview with the nurse confirmed this practice. The designated health authority (DHA) reviewed the HRH prior to the completion of the Comprehensive Physical Assessment (CPA). The DHA's review of the HRH was documented on the CPA in each case.

4.13 Comprehensive Physical Assessment	Satisfactory Compliance
The standardized Comprehensive Physical Assessment form shall be used for all youth admitted into the physical custody of a DJJ facility.	

Seven youth healthcare records were reviewed for a Comprehensive Physical Assessment (CPA). The program's policy and practice is to complete a new CPA on each youth, even if a current CPA is available in the commitment packet. The interview with the nurse confirmed the policy. Each record contained a current CPA in the commitment packet, as well as, a new CPA completed at the program within seven days by the designated health authority (DHA). All sections of the CPAs were addressed and documented in accordance with Department requirements. Six of the seven CPAs documented the correct medical grade. One CPA listed the youth as a medical grade one, but the youth was a medical grade two. Other documents, such as the Department's Problem List and physician order, had the correct medical grade for the youth and services were provided in accordance with the youth being a medical grade two.

4.14 Female-Specific Screening/Examination	Non-Applicable
All adolescent girls shall receive gender-appropriate screenings, examinations, and tests to address their unique needs.	

This is an all-male program; therefore, this indicator rates as non-applicable.

4.15 Tuberculosis Screening	Satisfactory Compliance
All youth shall be screened for Tuberculosis, and accurate documentation of results shall be maintained by each facility.	

Seven youth healthcare records were reviewed for tuberculosis screening. The date of a current tuberculosis screening test (TST) completed prior to admission and the results were documented on the Comprehensive Physical Assessment (CPA) and Infectious Communicable Disease (ICD) form in each case. Two youth required an annual update to the TST after admission, which was completed and documented on the ICD form in each case. The interview with the nurse revealed he knew the requirements for a current TST at admission and an annual update.

4.16 Sexually Transmitted Infection Screening	Satisfactory Compliance
The program shall ensure all youth are evaluated and treated (if necessary) for sexually transmitted infections (STIs).	

A review of seven youth healthcare records found a Sexually Transmitted Infection (STI) Screening form was completed by a nurse (RN) on the day of admission in each case. Each STI Screening was reviewed by the designated health authority (DHA) within a week of admission. All seven youth were referred for and received STI testing. The STI testing results were documented on the Infectious Communicable Disease (ICD) form and filed in the lab section of each record. The nurse interview revealed he was familiar with STI screening requirements.

4.17 HIV Testing	Satisfactory Compliance
The program shall routinely offer counseling, testing, and referrals for medical treatment to all youth at risk for HIV infection.	

Human immunodeficiency virus (HIV) testing is provided through Community Outreach, which is associated with the Volusia County Health Department. Community Outreach comes to the program to offer and complete testing. The certifications for the Community Outreach staff who perform the HIV services and testing were on file at the program. Seven youth healthcare records were reviewed, which indicated each youth was offered testing upon admission. All seven youth refused HIV testing at admission, though four youth later consented to testing when Community Outreach was on-site providing HIV education in July 2018. The four youth who consented to testing were tested. Pre-test and post-test counseling was documented on the Health Education Record for each youth. Test results were appropriately filed in each youth's healthcare record in a sealed envelope marked confidential. The nurse was interviewed and able to explain how HIV services are provided at the program. All seven youth interviewed said they could ask for a HIV test.

4.18 Sick Call Process – Requests/Complaints	Satisfactory Compliance
All youth in the facility shall be able to make Sick Call requests and have their complaints treated appropriately through the Sick Call system.	

Sick call is conducted daily between 1:00 p.m. and 2:00 p.m. by a licensed nurse, exceeding the contract requirement which requires sick call to be conducted four times a week. Sick call request forms are available to youth in the dining room and on the dorm. Youth complete sick call request forms and place them in a secured box. Nursing staff retrieve the sick call requests daily. No youth presented with a similar complaint three times in a two-week period and no youth made a complaint with which staff were unfamiliar. Seven youth were interviewed. Three youth reported they could see a nurse within one day of submitting a sick call request, three youth said three days, and one said he had not requested sick call. The interview with the nurse confirmed the frequency of sick call, the process for youth completing sick call forms, and nursing staff checking the sick call boxes daily.

4.19 Sick Call Process – Visits/Encounters	Satisfactory Compliance
The facility shall respond appropriately, in a timely manner, and document all Sick Call encounters, as required by the Department.	

Seven youth healthcare records were reviewed, which included eight sick call encounters. Each sick call was completed by a nurse. Five sick calls were completed by the licensed practical nurse (LPN). The LPN documented a consult with the registered nurse (RN) in each case. All sick calls were documented in the SOAP (subjective, objective, assessment, and plan) format and reflected required elements, such as vital signs, education, and care provided. Youth were provided with instructions and follow-up care was provided, as needed. All sick calls were documented in the sick call log and on individual youth sick call index forms. A sick call was observed, to which the youth receiving the sick call care consented. The nurse completing the sick call completed a general assessment of the youth and thoroughly addressed the youth's issue. Seven staff were interviewed and reported sick call care is provided by nurses.

4.20 Restricted Housing	Non-Applicable
All youth in Room Restriction/Controlled Observation s shall have timely access to medical care, as required by the Department.	

The program's policy, procedures, or contract states they do not use restricted housing, to include confinement, seclusion, room restriction, or secure observation; therefore, this indicator rates as non-applicable.

4.21 Episodic/First Aid Care	Satisfactory Compliance
The facility shall have a comprehensive process for the provision of Episodic Care and First Aid.	

Seven youth healthcare records were reviewed, which included fifteen instances of episodic care. Each episodic care event was documented by a nurse in the SOAP (subjective, objective, assessment, and plan) format. The nurse documented instructions for the youth in all cases and youth were referred for additional care, if needed. All instances of episodic care were documented in the episodic care log.

First aid kits are located in master control, a classroom, the kitchen, and case management. There were kits for each vehicle stored in master control. The designated health authority (DHA) has identified and approved required contents for the first aid kits. All first aid kits observed were fully stocked with items approved by the DHA. Also included in the first aid kits are Report of On-Site Healthcare by Non-Healthcare Staff forms for staff to document care provided with items from the first aid kits. The kits are secured with breakaway tabs, thus is it known when kits are opened, and supplies are taken. Supplies are restocked whenever items are used or when they expire. Nursing staff documented weekly checks of all first aid kits to ensure all required contents were present and within date.

4.22 Emergency Care	Satisfactory Compliance
The facility shall have established processes and procedures for either directly providing Emergency Care or facilitating an appropriate response to an emergency situation.	

A review of nursing staff records and thirteen staff training files found all had current certifications in first aid, cardiopulmonary resuscitation (CPR), and use of an automated external defibrillator (AED). Documentation of medical drills for 2018 was reviewed, finding medical drills were conducted at least once a quarter on each shift. The drills included a CPR demonstration at least once a quarter and each shift had three drills with a CPR demonstration in 2018. The drills were well documented, using an internal form and pictures showing staff response included with the drill form.

The program has one AED, which is kept in master control. The battery for the AED was just changed in July 2018 and the pads were well within the expiration date. The AED is checked monthly by nursing, which includes a review of expiration dates for the battery and pads. The nurse completed a test of the AED in front of the review team, showing it was in working order. A list of emergency numbers is kept in master control. Seven staff were interviewed. Six of the seven staff indicated they were allowed to call 9-1-1 in the event of an emergency. The remaining staff member indicated the nurse or supervisor calls 9-1-1. The nurse was interviewed and able to explain emergency care procedures.

Two instances of youth being taken to the emergency room were included in the sample of records reviewed. Staff responded appropriately in each case and there was appropriate follow-up by medical staff.

4.23 Off-Site Care/Referrals	Satisfactory Compliance
The facility shall provide for timely referrals and coordination of medical services to an off-site health care provider (emergent and non-emergent), and document such services as required by the Department.	

Seven youth healthcare records were reviewed, which included twelve instances of off-site care. A Summary of Off-Site Care form was completed by the off-site provider in each case, and discharge paperwork was completed if additional instructions were needed. The designated health authority (DHA) reviewed each Off-Site Summary of Care form and discharge paperwork. Follow-up care was scheduled, when needed. Parental notification for off-site care was documented in each case. The nurse interview showed he knew procedures for off-site care.

4.24 Chronic Illness/Periodic Evaluations	Satisfactory Compliance
The facility shall ensure youth who have chronic illnesses receive regularly scheduled evaluations and necessary follow-up.	

Seven youth healthcare records were reviewed, which included five youth with chronic conditions. All five applicable youth were evaluated by the designated health authority (DHA) within a week of admission. Periodic evaluations were tracked and scheduled using the Chronic Conditions List. The interview with the DHA and review of program policy and procedures indicated youth with chronic conditions will have periodic evaluations every two months, exceeding the Department requirement to conduct the evaluations every three months. The five records reviewed confirmed the period evaluations were completed every two months. The

periodic evaluations were completed on-site by the DHA and documented in the chronological record and physician orders sections of the healthcare record. Orders were clearly written, indicating medication to be taken and the plan to be followed. Youth on psychotropic medications were evaluated by the psychiatrist at least monthly. An interview with the facility administrator (FA) indicated the DHA conducts weekly visits and quarterly meetings are held with the treatment team to review important medical issues pertaining to the youth. The FA also indicated the health services administrator reviews any youth medical issues during the morning management meeting. An interview with the DHA confirmed youth medical issues are reviewed with healthcare staff during the DHA's weekly visit, and the nurse will discuss each youth seen and the reason for being seen. The DHA reported the youth are discussed prior to being seen and treatment. The DHA also stated quarterly meetings are held with treatment teams.

4.25 Medication Management – Verification	**Satisfactory Compliance**
A youth's medication regimen shall be ascertained upon admission to the facility.	

Seven youth healthcare records were reviewed, which included five youth who entered the program with medication. All youth were in a Department detention center prior to being transported to the program by detention staff. Nursing staff received the medication(s) and documented verification in the admission progress note. The nurse notified the designated health authority of the medication in each case and the psychiatrist was notified of youth admitted with psychotropic medication. Each youth continued to receive their medication(s) as prescribed following admission.

4.26 Medication Management – Orders/Prescriptions	**Satisfactory Compliance**
All medications shall have a current, valid order and are given pursuant to a current prescription or Practitioner Order.	

Seven youth healthcare records were reviewed for medication management. Each youth was on medication. Current, valid medication orders were in place for each prescription medication and over-the-counter (OTC) medication to be taken on a regular basis. Medication orders were updated whenever medication monitoring or chronic condition evaluations occurred. Youth admitted with medication continued the medication in accordance with the order.

4.27 Medication Management – Storage	**Satisfactory Compliance**
All medications (e.g., prescriptions, over-the-counter, topical) are stored in separate, secure (locked) areas inaccessible to youth.	

All medications are stored in the medical clinic. All active medications, to include all prescription and controlled medications, are stored in a secured medication cart. The controlled medications are stored in a locked drawer within the medication cart and are behind two locks. Over-the-counter stock medications are stored in a secured cabinet. Medications were stored separately by type (oral, topical, nasal sprays, injectable, and eye drops) and by youth. There is separate refrigerator for medication requiring refrigeration. All medication storage was clean and organized. Sharps are secured in a locked cabinet.

The program has a modified Institutional Class II Type B pharmacy permit. The program has a policy and procedures in place for the disposal of controlled medications and to return unused non-controlled medications to the pharmacy for credit or disposal. The program maintains a log

to document when medications are returned to the pharmacy or disposed. The consultant pharmacist disposes of controlled medication on-site. The disposal of controlled medications has to be witnessed by at least two staff. Forms used to document the disposal of controlled medications were signed by the consultant pharmacist and two staff.

4.28 Medication Management – Medication and Sharps Inventory	Satisfactory Compliance
All medications and sharps shall be inventoried as per department requirements.	

The program maintains working and bulk supplies of over-the-counter (OTC) medications. Documentation showed the bulk supply of OTC medication is inventoried at least weekly and perpetually when the active supply is replenished. Documentation showed the working supply of over-the-counter (OTC) medication and prescribed medication are perpetually inventoried and inventoried daily. Documentation showed sharps are inventoried at least weekly and perpetually when sharps are used. Three active OTC medications, three bulk supply OTC medications, six prescribed controlled medications, and three sharps were counted in the presence of a member of the review team. The counts for each medication and sharp matched the ending inventory. The program has a process in place to correct and report inventory discrepancies.

4.29 Medication Management – Controlled Medications	Satisfactory Compliance
All controlled substances shall be inventoried, stored, and documented, as per Board of Pharmacy and Department requirements.	

The program has a policy and procedures to address medications, which includes storage and inventory requirements for controlled medications. All controlled substances are kept in a secured medication cart, securing them behind a double-lock system. The morning medication pass was observed, which included six youth receiving controlled medication. The nurse updated the controlled medication inventory for each youth once the medication was administered. Each controlled medication inventory was reviewed, finding the inventories were maintained perpetually and for each nursing shift. There were two signatures for the shift-to-shift inventories, which included at least one nurse signature. Six prescribed controlled medications were counted in the presence of a member of the review team and all controlled medication inventories were found to be accurate.

4.30 Medication Management – Medication Administration Record	Satisfactory Compliance
The standard Department Medication Administration Record (MAR) shall be maintained at the facility for each youth who has a current, valid medication order.	

Medication Administration Records (MARs) were present for each youth. The MARs were completed by month, with MARs including prescription medication and over-the-counter (OTC) medications given based on standing orders. The MARs are pre-printed by the pharmacy. Nursing staff will add to the MARs if new medications are prescribed or orders are changed during a month. Each MAR included all required information, to include the youth's name, Department identification number, date of birth, allergies, precautions, and medical grade. The admission card for each youth, which includes a picture of the youth, is maintained with the youth's MAR in a notebook containing all the MARs for the month. Start and stop dates were documented for each medication, with the dates being updated or corrected by hand when orders were updated. Monitoring for side effects was documented each time medication was

administered. Observation of medication administration revealed the nurse asked each youth about side effects when giving them their medication.

4.31 Medication Management – Medication Administration by Licensed Staff	Satisfactory Compliance
Medication Administration shall occur as scheduled in a comprehensive, accurate, and organized manner in the facility, only by a licensed nurse.	

All medications is administered by licensed medical staff. Trained non-licensed staff may administer over-the-counter medications in accordance with protocols and non-parenteral prescription medications when nursing staff are not on-site. A review of Medication Administration Records (MARs) showed licensed healthcare staff appropriately documented medication administration. The program has not had any youth on parenteral medications during the annual compliance review period. Policy and procedures state only medical staff may administer parenteral medication or assist youth in self-administration of parenteral medication. Medication administration was observed. The medication cart was placed in the doorway to the clinic and only the nurse had access to the medications. A staff member stayed on the other side of the cart in the hallway with the youth. Youth approached the medication cart one at a time. The nurse prepared each medication after the youth stated his name and his identity was confirmed. The nurse observed each youth swallow their medication and checked their mouth to ensure the medication was swallowed. The staff also observed each youth's mouth to ensure the medication was swallowed. Monitoring for side effects was documented each time medication was administered. Six of seven interviewed youth reported a nurse provides them their medication, with one youth indicating they do not take medication. One youth reported staff on each shift are medically trained to provide medication if the nurse is not available.

4.32 Medication Management – Medication Provided by Non-Licensed Staff	Satisfactory Compliance
Trained, non-health care staff may assist youth with self-administration of oral prescription medications or over-the-counter medications, only when licensed nurses are not available on site. The nurse shall delegate the delivery, supervision, and oversight of youth during self-administration of medications.	

The program has trained shift supervisors and youth care worker IIs (YCW II) in medication administration. A list of the supervisors and YCW IIs trained in medication administration is posted in the clinic. These staff acknowledged treatment protocols, which included administration of over-the-counter medication for minor conditions. There was one case in which supervisors or YCW IIs administered medication, which was for a prescription medication to be administered at 10:00 p.m. The medication was correctly administered by the staff, with staff and youth initials documenting each dose. Six of seven interviewed staff indicated the nurse provides medication to the youth, with one staff reporting after hours trained staff provide medication to the youth. One of seven interviewed youth reported staff on each shift are medically trained to provide medication if the nurse is not available.

4.33 Medication Management – Psychotropic Medication Monitoring	Satisfactory Compliance
The facility shall have a comprehensive process in place for the monitoring of psychotropic medications, to ensure youths' safety, as required by the Department.	

A psychiatric evaluation is completed on each youth admitted to the program. The evaluations are recorded on a form used by the psychiatrist and page three of the Department's Clinical Psychotropic Progress Note (CPPN), with psychotropic medication(s) information documented on page three of the CPPN. The evaluations include all required elements, to include identifying data, youth history, current or previous medications, and diagnosis. There were no emergency orders or standing orders for psychiatric care.

Seven youth healthcare records were reviewed. A psychiatric evaluation was completed on each youth within fourteen days of admission. Four youth were admitted with psychotropic medication and two youth were placed on psychotropic medication after admission. Three of the youth admitted with psychotropic medication had adjustments made to their medication or were prescribed new psychotropic medication. Monthly monitoring was completed by a psychiatrist for all six youth. All required information was documented on the CPPN for each monthly monitoring, including the initiation of new psychotropic medication, adjustments or discontinuations of existing medications, targeted symptoms, and side effects. Documentation showed new psychotropic medications were not started until written parental consent was received.

4.34 Infection Control – Surveillance, Screening, and Management	Satisfactory Compliance
The facility shall have implemented Infection Control procedures including prevention, containment, treatment, and reporting requirements related to infectious diseases, as per OSHA federal regulations and the Centers for Disease Control and Prevention (CDC) guidelines.	

Infection control is addressed in the program's policy and procedures and the exposure control plan. The procedures address prevention, containment, treatment, and reporting requirements for infectious disease. Infectious diseases include common self-limiting illnesses, common contagious illnesses, serious infectious diseases, Hepatitis A, B, and C, lice, scabies, methicillin-resistant staphylococcus aureus (MRSA), foodborne illnesses, bio-terrorism agents, chemical exposure, and other conditions caused by any other infectious agents. The procedures outline potential exposure for employees. Staff are offered a Hepatitis B vaccine during new hire orientation. Procedures address access to personal protection equipment. The designated health authority (DHA) reviewed the infection control procedures and exposure control plan in July 2018.

4.35 Infection Control – Education	Satisfactory Compliance
The facility's comprehensive Infection Control education plan shall include pre-service and in-service training for all staff, and youth infection control education, as per Centers for Disease Control and Prevention (CDC) guidelines.	

A review of seven youth healthcare records found each youth received education on infection control. The education included hand-washing techniques, personal hygiene, dental hygiene, respiratory etiquette, vaccinations, accident prevention, types of blood borne diseases, and prevention and transmission of communicable diseases. A review of thirteen staff training

records found all staff received training on infection control, which was provided by a licensed medical professional.

4.36 Infection Control – Exposure Control Plan	Satisfactory Compliance
The facility's exposure control plan shall meet the requirements of OSHA standards (29 CFR 1910), with maintenance and documentation of the plan, as per the requirements of the Department.	

The exposure control plan was reviewed and signed by the designated health authority (DHA) in July 2018. The plan meets Occupational Safety and Health Administration (OSHA) and Department requirements. The plan includes risk assessments and methods of compliance. There has not been an occupational exposure at the program and no incidents involving quarantining or hospitalization of staff and/or youth during the review period. An interview with the facility administrator indicated the exposure control plan is located in the facility operating procedures binder in the personnel office and case management area. The facility administrator reported the exposure control plan is reviewed with staff twice a year.

4.37 Prenatal Care – Physical Care of Pregnant Youth	Non-Applicable
The facility shall provide prenatal care at recommended intervals. High-risk pregnant youth shall be provided additional testing and services as recommended.	

This is an all-male program; therefore, this indicator rates as non-applicable.

4.38 Prenatal and Neonatal Care – Nutrition, Education of Youth, and Lactation	Non-Applicable
The facility shall provide nutritious foods in sufficient quantities meeting the standards of the minimum daily allowances for pregnant youth. Each pregnant adolescent shall receive prenatal, post-partum, and parenting education including topics directly related to health care issues and medical risk for pregnant adolescents. *The program provides education to pregnant and postpartum girls about infant care and lactation.*	

This is an all-male program; therefore, this indicator rates as non-applicable.

4.39 Prenatal and Neonatal Staff Education	Non-Applicable
All non-healthcare staff involved in the supervision or treatment of pregnant youth and their infants must receive appropriate education.	

This is an all-male program; therefore, this indicator rates as non-applicable.

Standard 5: Safety and Security

Overview

The program is a secure residential facility housing up to thirty-three male juvenile sex offenders. Perimeter fencing is topped with no-climb mesh and razor wire. Direct care staff are primarily responsible for the supervision of youth, movement, searches, and application of the behavior management system. Staff use two-way radios to communicate movements, counts, and other information. The physical plant worker is responsible for tools, chemicals, and all physical aspects of the facility. It should be noted, the physical plant worker resigned, effective immediately, during the annual compliance review. All interior areas are under electronic surveillance, which includes a camera system with twenty-nine operable cameras capable of storing up to thirty days of footage.

5.01 Youth Supervision	Satisfactory Compliance
Program staff shall maintain active supervision of youth, including interacting positively with youth, engaging in a full schedule of constructive activities, closely observing behavior of youth and changes in behavior, and consistently applying the program's behavior management system (BMS). Program staff can account for the whereabouts of youth under their supervision at all times.	

The program has a policy and procedures in place for youth supervision. Staff were observed during movement, preparing for a transport, during school activities, outside recreation, and serving of meals. Staff interacted appropriately with youth, speaking respectfully and redirecting youth as needed. Staff were aware of youth placed on high security alerts and were observed maintaining accountability of all youth. Staff were positioned appropriately for optimal supervision most of the time. Youth were involved in a full schedule of constructive activities. Seven staff interviewed reported youth counts are conducted every hour and re-counts are conducted if there is a discrepancy. Youth movement is also restricted if a count does not clear. Observations in the classroom, recreation, and dining room found the program to be in compliance with the one-to-six staff-to-youth ratio.

5.02 Comprehensive and Consistent Implementation of the Behavior Management System and Staff Training	Satisfactory Compliance
The program shall have a detailed written description of the collaborative behavior management system (BMS). The written description is conspicuously posted and provided in a resident handbook to allow easy access for youth, including rules governing conduct and positive and negative consequences for behavior including while in the classroom. *All staff shall be trained in the behavior management system (BMS) employed at the program.*	

The program has a written comprehensive behavior management system (BMS) in place, which is designed to help transition the youth back into the community. The program uses a variety of awards/incentives after all goal objectives are met to encourage participation. The youth handbook outlines the five levels of the BMS, which are orientation, recruit, rookie, pro, and all-star. Seven reviewed youth records indicated the youth receive an orientation on the day of admission to include a review of the program's BMS. Privileges begin after fourteen days in the program if the youth has demonstrated positive behavior. Youth are awarded a variety of activities and snacks and higher-level youth are afforded the opportunity to assist in extra duties

within the program. Each level is discussed and approved by the multi-disciplinary treatment team after specific behavior is achieved and goals are accomplished. Youth can earn points daily through the “do right” system and are allowed to spend points at the super point store. A review of youth records and staff training records indicated youth and staff have been trained on the BMS. Youth interviewed indicate the consequences are fair and they are given a chance to explain themselves and discuss alternative behaviors. According to the assistant facility administrator (AFA), staff are trained in shift briefings and during monthly all campus meetings to remember the four-to-one ratio. Seven youth interviewed had a fair understanding of the BMS. Two youth rated the BMS system as good, one youth rated it fair, two youth rated it as poor, and two youth rated it as very poor. Six staff interviewed had a good understanding of the BMS.

An interview with the facility administrator regarding the behavior management system indicated youth receive behavior reports as a tool of redirection for any negative behaviors. The youth are “benched” for a number of days depending on their level in the program. The facility administrator reported if a youth displays positive behavior, they can receive a “do right,” which is worth three points. Points can be used at the super point store to purchase snacks, hygiene products, and other products available.

5.03 Behavior Management System Infractions and System Monitoring	**Satisfactory Compliance**
The program’s behavior management system (BMS) is designed to maintain order and security, provide constructive discipline and a system of positive and negative consequences to encourage youth to meet expectations for behavior, provide opportunities for positive reinforcement and recognition for accomplishments and positive behaviors, promote dialogue and peaceful conflict resolution, and minimize separation of youth from the general population. *Supervisors shall monitor staff implementation of the behavior management system (BMS), and ensure the use of rewards and consequences are administered fairly and consistently in application among all staff.*	

The program utilizes a level system, supplemented by status reports, which serve as a guide to appropriate consequences for youth and are maintained by the vocational instructor and assistant facility administrator (AFA). The program uses a variety of awards/incentives to encourage youth to meet goals and objectives. Consequences may range from level suspensions, loss of privileges, treatment team plan revisions, apology letters, being “benched” (early bedtime), and/or receive a level freeze until the problem behavior is corrected. Pre-treatment team meetings are scheduled to discuss behavior reports and decide if the consequences are appropriate. The special treatment team and the status behavior reports are used to monitor the BMS. The program’s behavior management system allows for youth and staff to discuss the reason for any sanctions imposed. Supervisors review the behavior reports and monitor staff for appropriate implementation of the behavior management system. The management team discuss issues with youth during weekly community meetings and observe staff and youth interactions and interventions. The program does not use room restriction as part of the BMS. Violations are designed to match the level of inappropriate behavior. The program’s position description for youth care workers includes language regarding the fair and consistent implementation of the behavior management system. For applicable staff, the annual performance evaluation includes the staff’s implementation of the program’s behavior management system.

Seven youth were interviewed and indicated youth are never allowed to punish other youth. Seven interviewed staff indicated youth receive positive reinforcement for positive behaviors. All interviewed staff reported understanding the four-to-one ratio for rewards to consequences and youth being provided various types of rewards for positive behaviors. Five of seven interviewed staff reported they receive feedback from supervisors regarding the implementation of the behavior management system during briefings, monthly meetings, or at the end of their shift. Two staff reported they do not receive any feedback from supervisors.

An interview with the facility administrator indicated staff are trained in shift briefing and during the monthly all campus meetings regarding the four-to-one rewards to consequences ratio as part of the behavior management system. The youth's consequences are monitored through special treatment team meetings and daily status reports. The facility administrator reported management conducts daily observations of staff interaction and intervention. It was reported issues are discussed with the management team and with the youth during community meetings, advisory board meeting, and treatment team meetings.

5.04 Ten-Minute Checks (Critical)	**Satisfactory Compliance**
A residential commitment program shall ensure staff observe youth at least every ten minutes while they are in their sleeping quarters, either during sleep time or at other times, such as during an illness or room restriction. Staff shall conduct the observations in a manner to ensure the safety and security of each youth and shall document real time observations manually or electronically.	

The program has a policy and procedures in place regarding checks of youth in their sleeping rooms. A random sample of videos were reviewed during varied dates and times on all three shifts. All checks were conducted within the required time frame of ten minutes and the majority were conducted within eight minutes. Checks were documented on the check sheet in real time and identified by the staff conducting the check. The supervisor conducts fidelity checks during each shift, verified by the check sheets and video camera. Check sheets are reviewed by the assistant facility administrator (AFA). Seven interviewed staff indicated checks are conducted every eight minutes, but no more than ten minutes.

5.05 Census, Counts, and Tracking	Satisfactory Compliance
The program ensures youth are accounted for at all times through a system of physically counting youth at various times throughout the day. *The program shall conduct and document resident counts minimally at the beginning of each shift, after each outdoor activity, and during emergency situations such as escapes or riots.* *The program shall maintain a chronological record of events as they occur, or, if an event disrupts the safety and security of the program, as soon as is practicable after order has been restored.* *The program tracks daily census information, including, at a minimum, the total daily census count, new admissions, releases or direct discharges, transfers, and youth temporarily away from the program. If at any time staff cannot account for the whereabouts of any youth, or discrepancies are found between resident counts and census information, the program reconciles immediately and takes follow-up action as needed.*	

The program has a policy and procedures in place addressing youth counts. The program's policy requires six formal and informal counts within a twenty-four-hour period, which consists of head counts, counts for each movement, and emergency counts. A review of logbooks and review team observation of counts confirmed this practice. Counts are called over the radio prior to and following the movement of youth. For formal head counts, all movement stops until the count is cleared. Counts for program drills were logged in the logbook and notated on the drill form. New admissions, transfers, and releases were logged into the program logbook, as were any youth who were off-site. Seven staff interviews indicate the staff are aware of when counts are conducted and the appropriate action to take when the count is not cleared.

5.06 Logbook Entries and Shift Report Review	Satisfactory Compliance
The program maintains a chronological record of events, incidents, and activities in a central log-book maintained at master control, living unit logbooks, or both, in accordance with Florida Administrative Code. The program ensures direct care staff, including each supervisor, are briefed when coming on duty.	

The program has a policy and procedures in place regarding logbooks and shift reports. The program maintains one facility logbook, which is kept in the master control room by the shift supervisor or carried around during the day. The logbook is bound with numbered pages. Logbook entries are maintained by each shift and reviewed by the shift supervisor. The beginning of each shift includes standard entries, such as alerts, staff on duty, call-outs, counts, and behaviors of youth. A review of the logbooks for April, May, July, and September 2018 found administrators, supervisors, and direct care staff documented their review in the logbook. All entries were brief, legible, and signed by the staff making the entry. The entries included the date and time of the event being recorded. Significant incidents were documented, to include reports made to the Department's Central Communications Center (CCC).

5.07 Key Control	Failed Compliance
The program has a system in place to govern the control and use of keys including the following: • *Key assignment and usage including restrictions on usage* • *Inventory and tracking of keys* • *Secure storage of keys not in use* • *Procedures addressing missing or lost keys* • *Reporting and replacement of damaged keys*	

The program has a policy and procedures addressing key control. A master key list is maintained by the physical plant manager. Facility keys are kept in master control and distributed to the staff by the shift supervisor after briefing. Personal keys are kept in exchange for the program keys and logged into the key log. Permanent issue keys are given only to the facility administrator (FA), assistant facility administrator (AFA), and department heads. Restricted keys are maintained in a locked storage closet in the clerical area. Active and emergency keys are located in a key cabinet secured in master control. During the annual compliance review, four sets of keys were noted as missing on varied dates in the facility logbook, one of which was a duplicate set. The program did not have documentation to indicate the keys were located, or they followed proper security precautions, or the program's policy and procedures regarding missing keys. According to the program, one set of missing keys was assigned to a vehicle loaned to another program, but there was no documentation of the transfer. The second and third set of missing keys were found on a staff on-site. During the annual compliance review week, a team member waited twenty to twenty-five minutes to retrieve their keys from the visitor's key box because no one knew the location of the key and the physical plant manager did not have a master key on-site. A random sample of keys were reviewed for accountability. The key inventory in master control did not match the keys secured in the locked box. The inventory was updated on-site during the annual compliance review. A random review of the restricted key inventory for keys was listed accurately with the key numbers and number of keys. Staff interviewed were aware of the key control policy and procedures to address missing or lost keys. It should be noted, the physical plant worker resigned, effective immediately, during the annual compliance review.

5.08 Contraband Procedure	Satisfactory Compliance
The program shall develop and implement a system to prevent the introduction of contraband into the program. *A residential commitment program shall delineate items and materials considered contraband when found in the possession of youth. The program shall provide youth with the list of contraband items and materials and inform the youth of the consequences if found with contraband. The program shall establish a system to prevent the introduction of contraband and identify contraband items and materials through searches of the physical plant, facility grounds, and its youth.* *The program shall document the confiscation of any contraband and the manner of disposition. The program shall keep a copy of the documentation in the case file. If a confiscated item is not illegal, the program director or designee has the discretion to discard the item, return it to its original owner, mail it to the youth's home, or return it to the youth upon release. In all instances involving confiscation of illegal contraband, the program shall turn the item over to local law enforcement.*	

The program has a policy and procedures designed to prevent contraband from being brought into the facility. Items considered contraband are outlined in the student handbook and discussed during orientation. Searches are conducted when youth enter the program, prior to movement, transports, and after activities. Contraband searches are completed on an irregular, random, weekly basis. A contraband room search log is completed by staff and maintained in a binder by the assistant facility administrator (AFA). The facility administrator will determine the method in which the contraband is disposed. Staff interviewed were aware of the protocol when contraband is found. No contraband was found during this annual compliance review period.

5.09 Searches and Full Body Visual Searches	Satisfactory Compliance
The program shall perform searches to ensure no contraband is being introduced into the facility.	

The program has a policy and procedures in place regarding searches of youth. The program policy states searches are conducted daily, and full body searches are conducted as needed. A youth search form is completed by staff and maintained in a binder by the assistant facility administrator (AFA). A search following classroom activities, lunch and recreation was observed. The youth were treated respectfully, and the search was conducted by male staff and in accordance with Protective Action Response (PAR). Seven youth were interviewed and stated they were searched regularly, which is in accordance with the search policy. Seven interviewed staff reported searches are conducted every movement, after visitation, and after outside recreation.

5.10 Vehicles and Maintenance	Satisfactory Compliance
All vehicles transporting youth shall receive appropriate maintenance and contain safety and emergency equipment so they may be operated in a safe manner. *The program ensures any vehicle used by the program to transport youth is properly maintained, and maintains documentation on the use and maintenance of each vehicle. Each vehicle being used for transport of youth shall pass an annual safety inspection. Each vehicle used to transport youth is equipped with the appropriate number of seat belts, a seat belt cutter, a window punch, a fire extinguisher, and an approved first aid kit. Youth and staff wear seat belts during transportation, and youth are not attached to any part of the vehicle by any means other than proper use of a seat belt.*	

The program utilizes four vehicles, but only three were on-site during the annual compliance review. Two vehicles are used to transport youth and one vehicle is used to transport equipment. One of the two vehicles used to transport youth did not have the annual service inspection as required or any documentation of maintenance. The program did schedule the vehicle for an oil change during the annual compliance review week after the findings were reported. The other vehicles had two inspections during the year. Program policy requires seatbelts to be used by youth and staff. The vehicles used for transportation of youth had all required equipment, including seat belts, a seat belt cutter, a window punch, and a fire extinguisher. The first aid kits are kept in master control and checked out prior to transport.

5.11 Transportation of Youth	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a policy and procedures in place regarding the transportation of youth. The policy requires a one-to-five staff-to-youth ratio for transporting youth, with a minimum of two staff. Youth are not able to open doors from the inside and all vehicles are equipped with a safety screen separating youth from the driver. A return trip was observed during the annual compliance review week and mechanical restraints were used in accordance with Florida Administrative Code. The program maintains an approved driver list, which is updated monthly. Seven staff interviewed said they do not transport youth in personal vehicles, they take a cell phone/radio, and first aid kit on transports, and seatbelts are always required. A random check of program and personal vehicles found all were secure when not in use.

5.12 Weekly Safety and Security Audits	Satisfactory Compliance
Appropriate minimum staff to youth staffing patterns shall be maintained while youth are transported off facility grounds to ensure the safety and security of youth, staff, and the public.	

The program has a policy and procedures in place regarding safety and security audits. The program has a system in place to ensure audits are conducted weekly by the assistant facility administrator (AFA). A random sample of weekly safety and security audits were reviewed for the past six months, which showed checks were completed every seven days. Deficiencies were noted, and corrective action was either taken or are being addressed. The AFA completes weekly safety inspections and then forwards them to corporate for review. The facility had a system in place to identify the deficiency and discuss the corrective action during shift briefings and daily meetings.

5.13 Tool Inventory and Management	Satisfactory Compliance
The facility shall have a tool management system ensuring youth do not use tools or equipment as weapons or security breaches.	

The program has a policy and procedures in place regarding tool inventory and management. The tool policy restricts the use of tools by youth. Tools are marked and displayed on a shadow board in maintenance and in the cleaning closet located on the living unit. Class A tools (i.e. hammers, screwdrivers, and tools with sharp edges) are secured in the maintenance area and are secured by the physical plant manager, logged daily when used, and reviewed monthly. A tag is placed on the shadow board when a tool is removed. Class B tools (i.e. mops, brooms, and other such tools used for cleaning) are kept in a cleaning supply room on the unit and are logged in and out as they are used. Staff and youth are trained on the use of class B tools. Inventories were accurate for all tools. All tools are secured behind a locked door when not in use.

5.14 Youth Tool Handling and Supervision	Limited Compliance
There shall be procedures to ensure youth use tools safely and are supervised appropriately in order to prevent injuries to the youth, other youth, and staff.	

The program has a policy and procedures in place regarding youth handling tools. All youth are given Class B tool training during orientation, to include the cleaning tools they will be expected to use during their stay in the program. Youth are given risk assessments prior to handling tools and assignments to work projects to assess their risk to self and others. Seven youth records were reviewed for completed risk assessments. A risk assessment is completed by the case manager and reviewed by the multi-disciplinary team. All seven youth had a current risk assessment and tool training. During the annual compliance review week, one youth was observed handling a Class A tool repairing the lock to the master control door and the risk assessment tool did not identify the youth as being eligible to handle tools. The tools were in close proximity to other youth at the time of repair. The policy states the program requires a one-to-five staff-to-youth ratio for work projects. Observations found the program was in compliance with ratio requirements during the incident with the youth repairing the master control lock (1:1), as well as for the duration of the annual compliance review. Seven staff were interviewed and indicated youth use mops, scrub brushes, and other tools. Seven youth were interviewed and indicated youth use brooms, mops, rakes, and other tools.

5.15 Outside Contractors	Satisfactory Compliance
The program shall establish guidelines required for outside contractors, which includes information about tool control and restrictions.	

The program maintains a sign-in log for outside contractors, which includes a log for tools. Sign-in sheets and logs for outside contractors were reviewed. All outside contractors completed the tool inventory form, which was reviewed and signed off by the physical plant manager. Project invoices submitted by the vendor were reviewed and the date the project was being worked on and/or completed matched the sign-in sheets. A vendor was on-site during the annual compliance review and all procedures were followed.

5.16 Fire, Safety, and Evacuation Drills	Satisfactory Compliance
The program shall conduct fire, safety and evacuation drills to ensure youth and staff are prepared for immediate implementation or mobilization in the event of an emergency or disaster.	

The program has a fire prevention plan in place. The program conducts regular fire, safety, and evacuation drills according to a schedule determined by the facility administrator, which was verified through a review of the program logbook. Drills are documented, detailing the date and time, type of drill, who was involved, the scenario, and results of the drill. Drill forms are reviewed by the facility administrator for recommendations. Evacuation and emergency drills are documented on a monthly basis. Seven youth were interviewed and indicated they were instructed on what to do in case of a fire. Seven staff were interviewed and indicated they had participated in various drills to include fire drills, escape drills, major disturbance, bomb threat, and weather drills. An interview with the facility administrator indicated fire drills are conducted twice a month on each shift. Drills conducted quarterly include severe weather, bomb threat, riot, and disturbance drills.

5.17 Disaster and Continuity of Operations Planning	Satisfactory Compliance
The program shall have a coordinated disaster plan and Continuity of Operations Plan (COOP) or one comprehensive plan incorporating both. The plan(s) shall provide for the basic care and custody of youth in the event of an emergency or disaster and continuity of the aforementioned, while ensuring the safety of staff, youth and the public. The plan shall be submitted to the regional director, or designee, for approval and signature.	

The program maintains a current continuity of operations plan (COOP). The plan was reviewed and approved on May 11, 2018 by the Department. The plan addresses alternative housing plans, delegation of authority, cooperative agreements, vendor contacts, emergency and staff contacts, and the county cooperation checklist. The COOP is located in the staff breakroom and case management area. An interview with the facility administrator indicated two copies of the COOP plan are located within the program with one being maintained in the personnel office and the other in the case management area.

5.18 Storage and Inventory of Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program director or designee shall maintain strict control of flammable, poisonous and toxic items and materials and a complete inventory of all such items.	

The program has a policy and procedures in place for the storage of all flammable, poisonous, and toxic items in secure areas. Chemicals are stored in the maintenance shed and the cleaning closet on the living unit. The program maintains an inventory of all chemicals, as well as, a chemical use log. Safety Data Sheets (SDS) were maintained in a binder by the physical plant manager. A review of the (SDS) binder indicated all matched the chemicals stored in the shed. The chemicals were stored properly and inaccessible to youth.

5.19 Youth Handling and Supervision for Flammable, Poisonous, and Toxic Items and Materials	Satisfactory Compliance
The program shall maintain strict control of flammable, poisonous, and toxic items and materials. *Youth shall not be permitted to use, handle, or clean dangerous or hazardous chemicals or respond to chemical spills. Youth shall not be permitted to clean, handle, or dispose of any other person's biohazardous material, bodily fluids, or human waste.*	

According to the program's policy, youth are not permitted to use, handle, or clean with hazardous chemicals or respond to chemical spills. Seven youth were interviewed and indicated they are only allowed to use laundry soap. Youth do not clean, handle, or dispose of any biohazardous material, bodily fluids, or human waste.

5.20 Disposal of all Flammable, Toxic, Caustic, and Poisonous Items	Satisfactory Compliance
The maintenance mechanic, or other trained staff who have the safety equipment for diluting, handling, and disposing of hazardous waste and/or solid waste, shall be responsible for disposing of hazardous items and toxic materials.	

The program has a policy and procedures in place for disposing of flammable, toxic, caustic, and poisonous material. All disposal of hazardous materials is required to be completed by the physical plant manager by taking the materials to the Volusia County Fire Station for appropriate disposal. The program indicated they have not disposed of any hazardous material during this annual compliance review period. Liquid waste from cleaning is disposed of in a mop sink in the cleaning closet. The kitchen is not used for cooking, so no waste is produced. The interview with the facility administrator found he is familiar with the policy for disposing of hazardous materials at the Volusia County Fire Department.

5.21 Recreation and Leisure Activities	Satisfactory Compliance
The program shall provide a variety of recreation and leisure activities.	

The program provides a variety of recreation and leisure activities. The program has a recreational therapist with the required credentials. The recreational program is a part of each youth's treatment plan. Logbooks were reviewed for recreational activity, which confirmed this practice. Seven interviewed youth stated the program provides different activities for recreation, to include different games and sports. Recreation was observed. Staff worked with each youth according to their ability and showed support for their efforts. Seven staff and youth interviews indicate youth are afforded one hour of large muscle activity a day either outside or on the unit if there is inclement weather.

5.22 Elements of the Water Safety Plan, Staff Training, and Swim Test (Critical)	Non-Applicable

Programs choosing to participate in water-related activities shall develop and implement a water safety plan to ensure proper supervision and safety of the youth during water related activities. The plan shall also ensure staff are appropriately trained for each specific type of water activity.

Programs allowing youth to participate in water-related activities shall have a water safety plan addressing, at a minimum, safety issues, emergency procedures, and the rules to be followed during water-related activities, as follows:

- *Determination of the risk level for each participating youth, including whether or not the youth can swim, an assessment of swimming ability, and other factors to include age and maturity, special needs such as physical and mental health issues, and physical stature and conditioning;*
- *Type of water, such as pool or open water;*
- *Water conditions, such as clarity, turbulence, and bottom conditions;*
- *Type of activity, such as swimming, boating, canoeing, rafting, snorkeling, scuba diving, and shoreline and offshore activities to include fishing from a bank or pier, fishing while wading, or picnicking close to a body of water.*
- *Lifeguard-to-youth ratio and positioning of lifeguards;*
- *Other staff supervision; and*
- *Safety equipment needed for the activity, such as personal flotation devices when youth are in a boat, canoe, or raft, and availability of a lifeline during shoreline and offshore activities.*

Programs choosing to participate in water-related activities shall ensure staff are appropriately trained for each specific type of water activity.

Programs choosing to participate in water-related activities shall assess each youth's aquatic ability prior to participation in water-related programming.

The program does not participate in any water-related activities; therefore, this indicator rates as non-applicable.

5.23 Visitation and Communication	Satisfactory Compliance

The program allows visitation and communication for youth while in the program.

The program has a policy and procedures in place regarding visitation and communication. The program ensures youth are afforded the opportunity to communicate with family members by mail, telephone, and visitation. An approved telephone and correspondence list is developed for youth during orientation. Staff will mail two letters for youth weekly at the program's expense. Youth are allowed to call family members weekly by the case manager. Visitation is held once weekly, monitored by staff. Seven youth interviewed indicated they are allowed to visit and communicate with their families.

5.24 Search and Inspection of Controlled Observation Room	Non-Applicable
The program shall conduct youth searches and room inspections prior to placing a youth on Controlled Observation.	

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

5.25 Controlled Observation	Non-Applicable
Programs shall only place youth in Controlled Observation when non-physical interventions would not be effective.	

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

5.26 Controlled Observation Safety Checks Release Procedures	Non-Applicable
The program shall conduct safety checks for youth on Controlled Observation. The program director or designee shall approve a release when it is determined, based on his or her behavior, the youth is no longer an imminent threat to self or others.	

The program's policy, procedure, and practice confirm the program does not use controlled observation; therefore, this indicator rates as non-applicable.

Program Name: Daytona Juvenile Residential Facility
Provider Name: TrueCore Behavioral Solutions, LCC
Location: Volusia County / Circuit 7
Review Date(s): September 25-28, 2018

MQI Program Code: 1226
Contract Number: R2107
Number of Beds: 33
Lead Reviewer Code: 167

Overall Rating Summary

The following limited and/or failed indicators require immediate corrective action.

Limited Ratings	Failed Ratings
5.14 Youth Tool Handling and Supervision	5.07 Key Control